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Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

October 21st, 2026

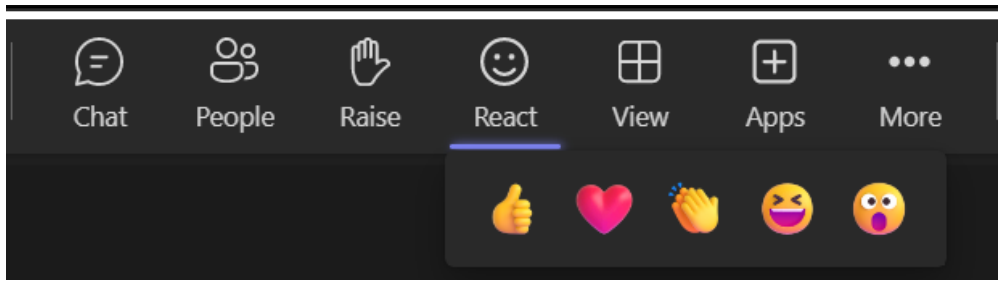
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:10 a.m.	**2.**	**Key Findings from *Report on Promoting High Value Health Care in California*, 2023-2024**
9:40 a.m.	**3.**	**Update on Behavioral Health Spending Analyses and Benchmark Setting**
10:25 a.m.	**4.**	**Next Steps**
10:30 a.m.	**5.**	**Adjournment**

Meeting Format

Reminder: Workgroup members may provide verbal feedback during the meeting. Non-Workgroup members are welcome to participate during the meeting via the chat or provide written feedback to the OHCA team after the meeting.

- Workgroup purpose and scope can be found in the Investment and Payment Workgroup Charter
- Remote participation via Teams Webinar only
- Meeting recurs quarterly
- We will be using reaction emojis, breakout rooms, and chat functions:



Date: October 21, 2026

Time: 9:00 am PST

Microsoft Teams Link
for Public Participation:
Join the meeting now

Meeting ID: 286 006 518 611 7
Passcode: v7u8Gr6z

Or call in (audio only):
+1 916-535-0978

Conference ID:
879 8430892#

Investment and Payment Workgroup Members

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Consumer Reps & Advocates

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Contract Lobbyist, Health Access California

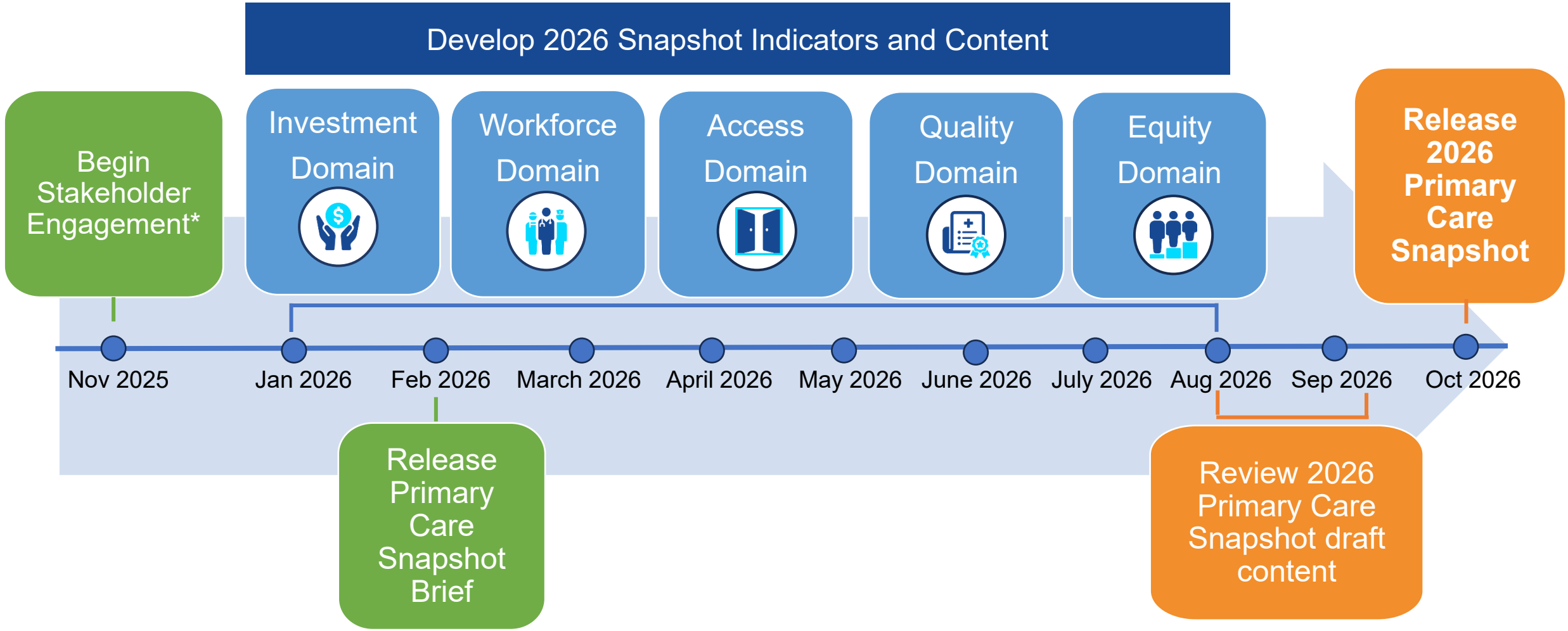
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Transplant Recipient and Cancer Survivor, Patients for Primary Care

Héctor Hernández-Delgado, Esq.
Senior Attorney, National Health Law Program

Cary Sanders, MPP
Senior Policy Director, California Pan-Ethnic Health Network (CPEHN)

2026 HCAI Primary Care Snapshot Timeline



For more information on the HCAI Primary Care Snapshot Workgroup: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/hcai-primary-care-snapshot-workgroup/

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Key Findings from *Report on Promoting High Value Health Care in California, 2023-2024*

Hamdi Abdullahi, Value-based Payment Group Manager
Debbie Lindes, Health Care Delivery System Group Manager

Report Overview

- Presents data on alternative payment model (APM) adoption and primary care spending in California for calendar years 2023 and 2024.
  - Markets included: Commercial, Medicare Advantage, Medi-Cal Managed Care
  - Data presented at statewide level and where applicable, by market and by payer
- Serves as a baseline assessment of APM adoption and primary care spending prior to the implementation of primary care annual improvement benchmarks (2025) and APM adoption goals (2026).
- Includes brief updates on additional work to promote high value system performance.
- Appendices identify data exclusions, data validation processes, APM and primary care methodologies, and context for Medi-Cal data.
- Complements the *Interim Report: Health Care Spending Trends in California, 2023-2024*, which reports on the rate of growth of total health care spending from 2023 to 2024.

Key Takeaways

- Statewide **APM adoption**, as measured by the percent of members attributed to capitation and full risk or shared savings and shared risk payment categories eligible for quality-linked payments, increased slightly from 70.5% in 2023 to 73.0% in 2024.
  - APM adoption increased in Medicare Advantage and Medi-Cal Managed Care markets, remained stable in Commercial HMO/POS** market, and declined in Commercial PPO/EPO** market.
- Statewide **primary care spending**, measured by spending on primary care services through claims and non-claims payments, increased slightly from 4.7% in 2023 to 4.8% in 2024 as a percent of total medical expense (TME).
  - Primary care spending growth was greatest in Medi-Cal Managed Care market,* with a slight increase in Medicare Advantage and slight decreases in Commercial HMO/POS and PPO/EPO markets.
- Statewide, although **over 85% of members** were attributed to a capitation payment arrangement, **nearly 70% of spending** was in fee-for-service in 2023 and 2024.

*Medi-Cal Managed Care covered benefits do not align with those in other markets, making cross-market comparisons unreliable (e.g. Medi-Cal Managed Care TME does not include retail pharmacy spending).
**HMO: Health Maintenance Organization; POS: Point of Service; PPO: Preferred Provider Organization; EPO: Exclusive Provider Organization

APM Adoption and Primary Care Spending Data Source

- Calendar year 2023 and 2024 data submitted by 33 payers with at least 40,000 members across Commercial, Medicare Advantage, and Medi-Cal Managed Care markets using the technical specifications outlined in OHCA's Total Health Care Expenditures Data Submission Guide (DSG) 2.0.
- **APM adoption** data includes:
  - Claims and non-claims payments, member attribution to payment arrangements with or without a link to quality, total member months of coverage, and total medical expense.
- **Primary care spending** data includes:
  - Claims and non-claims payments for primary care services, member months of coverage where a payment was made, and total medical expense.

Note: Due to rounding, numbers presented throughout this report may not add precisely to the totals provided.

APM and Primary Care Data Exclusions

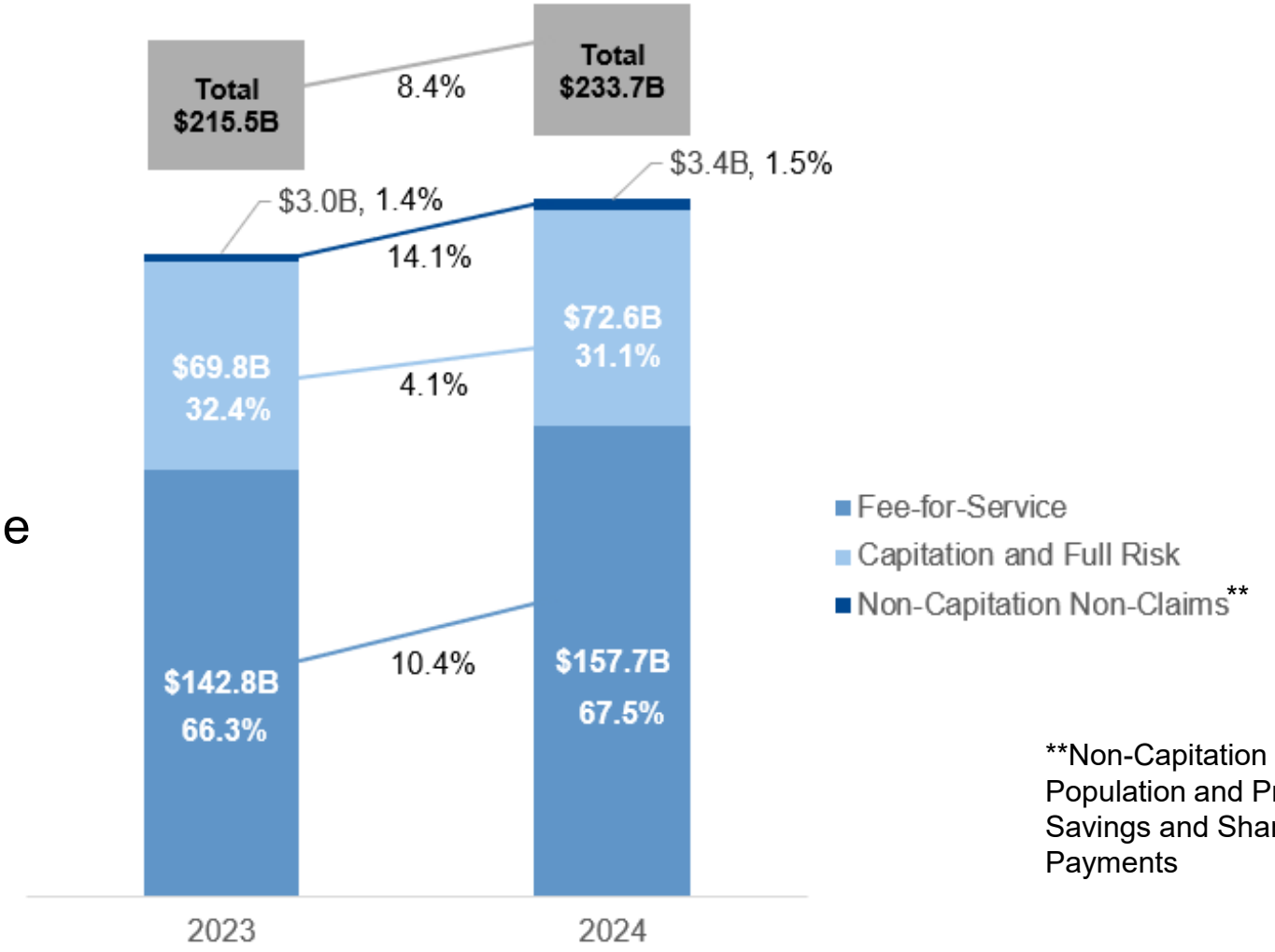
- Several payers' data has been excluded from APM and/or primary care reporting due to data validation concerns which OHCA is working with these payers to resolve.*
- Other exclusions:
  - Exclusion of two payers' data from the commercial PPO/EPO market due to low member months, and
  - Exclusion of spending in the "Commercial – Other" market category because enrollment and spending in this category represented less than 1% of the commercial market.

*See Appendix for list of specific payers whose data has been excluded from reporting.

APM Adoption Data, 2023-2024

Statewide Total Medical Expense (TME) within each Payment Category by Dollars and Percent of Total*

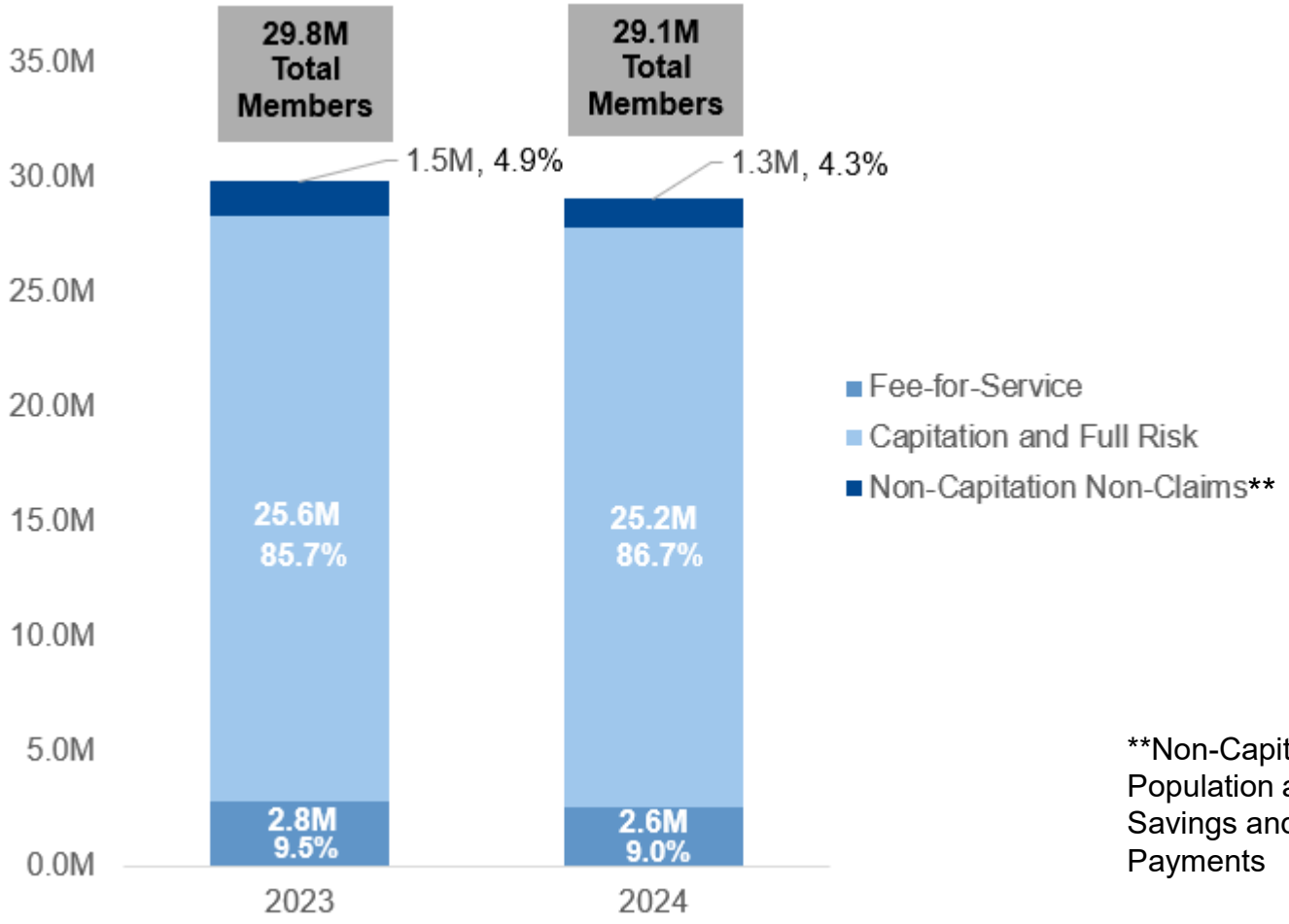
Year-over-year changes represent change in dollars spent



**Non-Capitation Non-Claims includes Performance Payments, Population and Practice Infrastructure Payments, Shared Savings and Shared Risk Payments, and Other Non-Claims Payments

*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

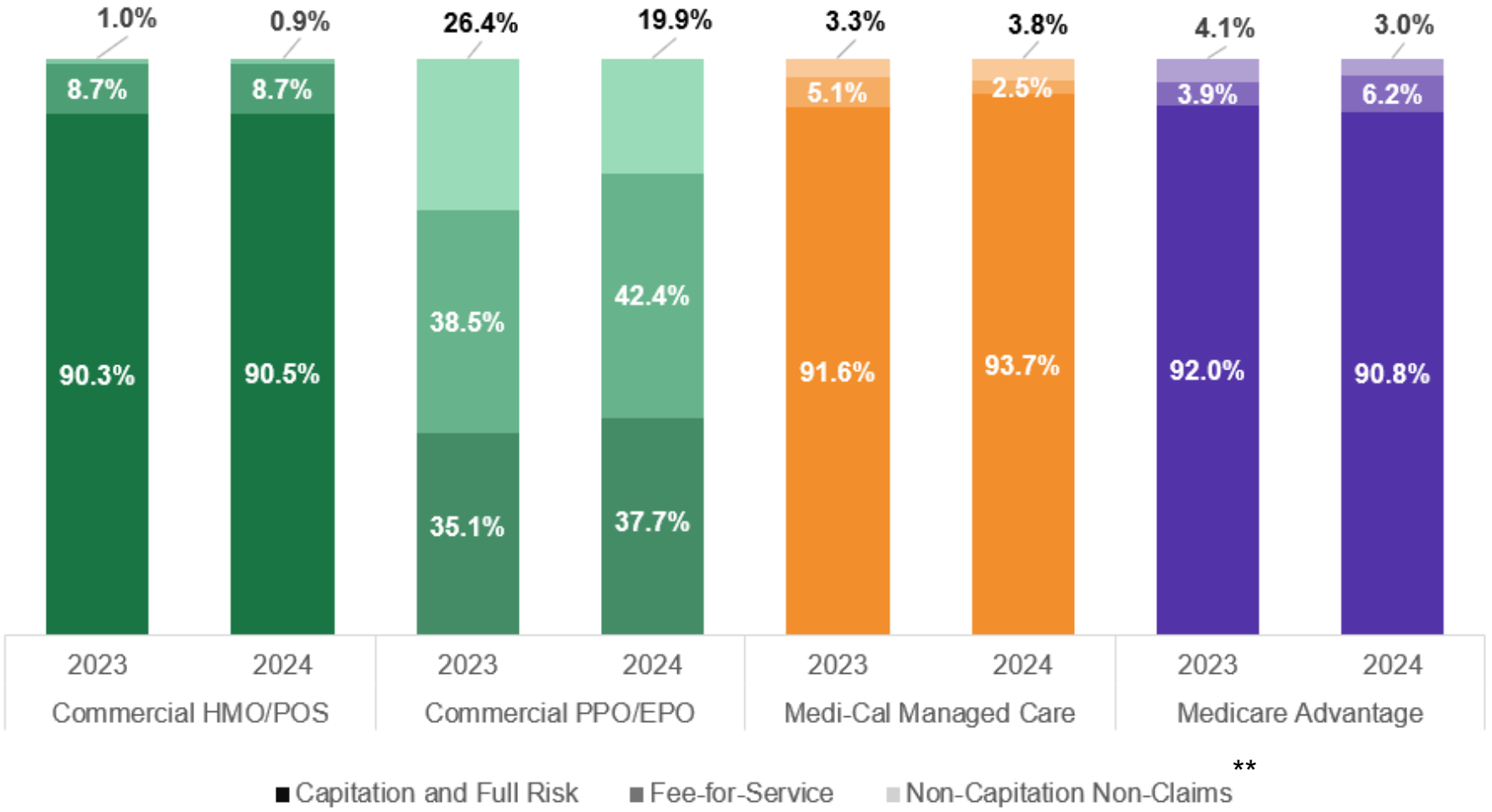
Count and Percent of Statewide Members by Attributed Payment Category*



**Non-Capitation Non-Claims includes Performance Payments, Population and Practice Infrastructure Payments, Shared Savings and Shared Risk Payments, and Other Non-Claims Payments

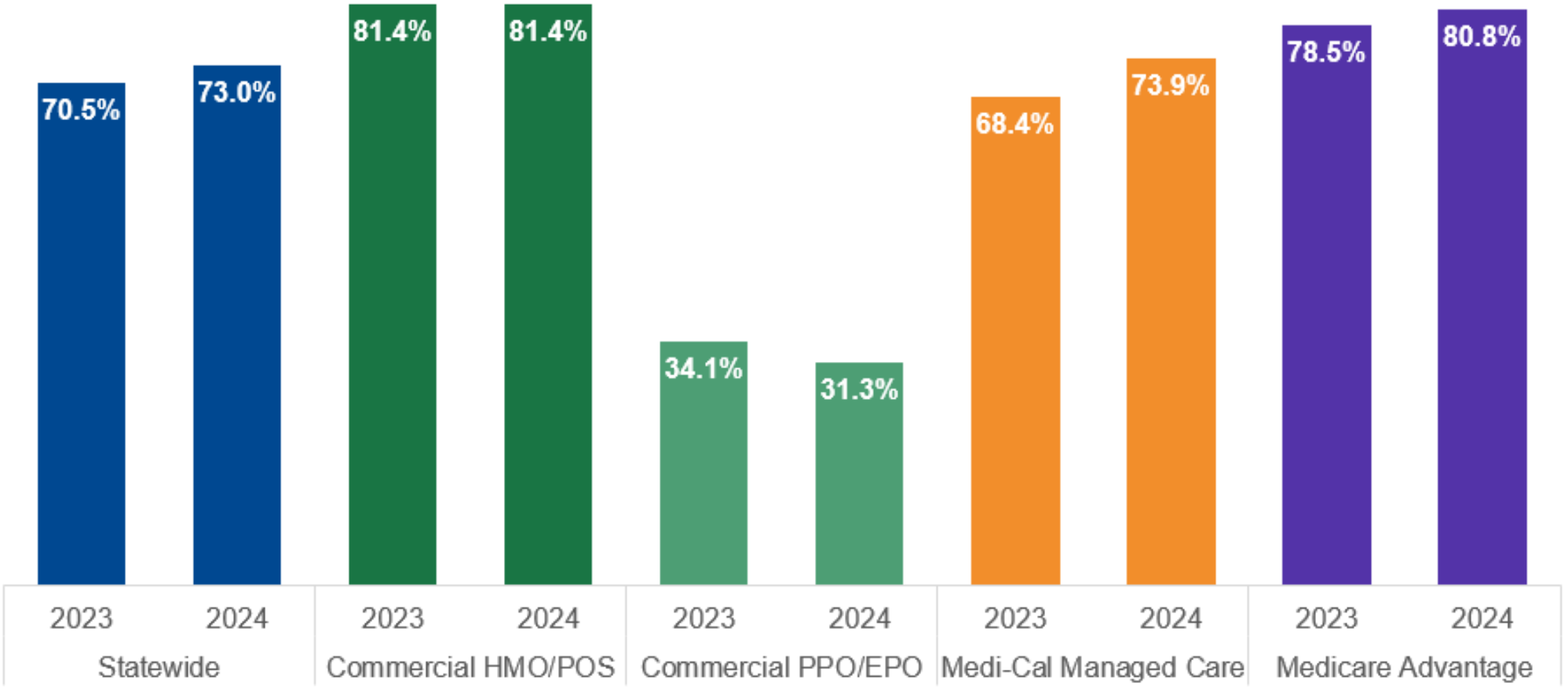
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

Percent of Members Attributed to Each Payment Category, by Market and Plan Type*



*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers. **Non-Capitation Non-Claims includes Performance Payments, Population and Practice Infrastructure Payments, Shared Savings and Shared Risk Payments, and Other Non-Claims Payments.

Percent of Members Attributed to APMs with Quality-Linked Payments Statewide and by Market and Plan Type*

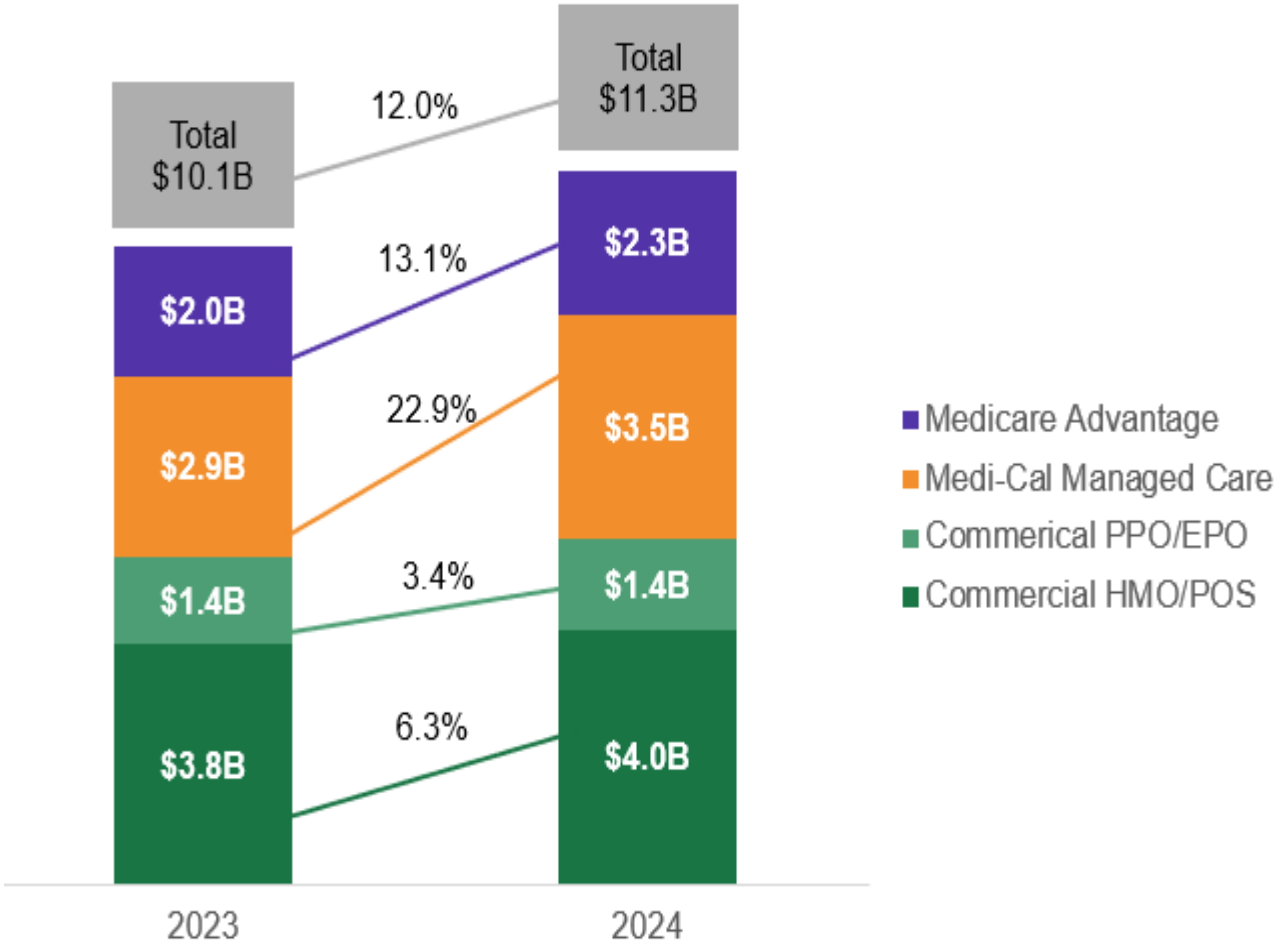


*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

Primary Care Spending Data, 2023-2024

Total Primary Care Spending in Billions and Primary Care Spending Growth, Statewide and by Market and Plan Type*

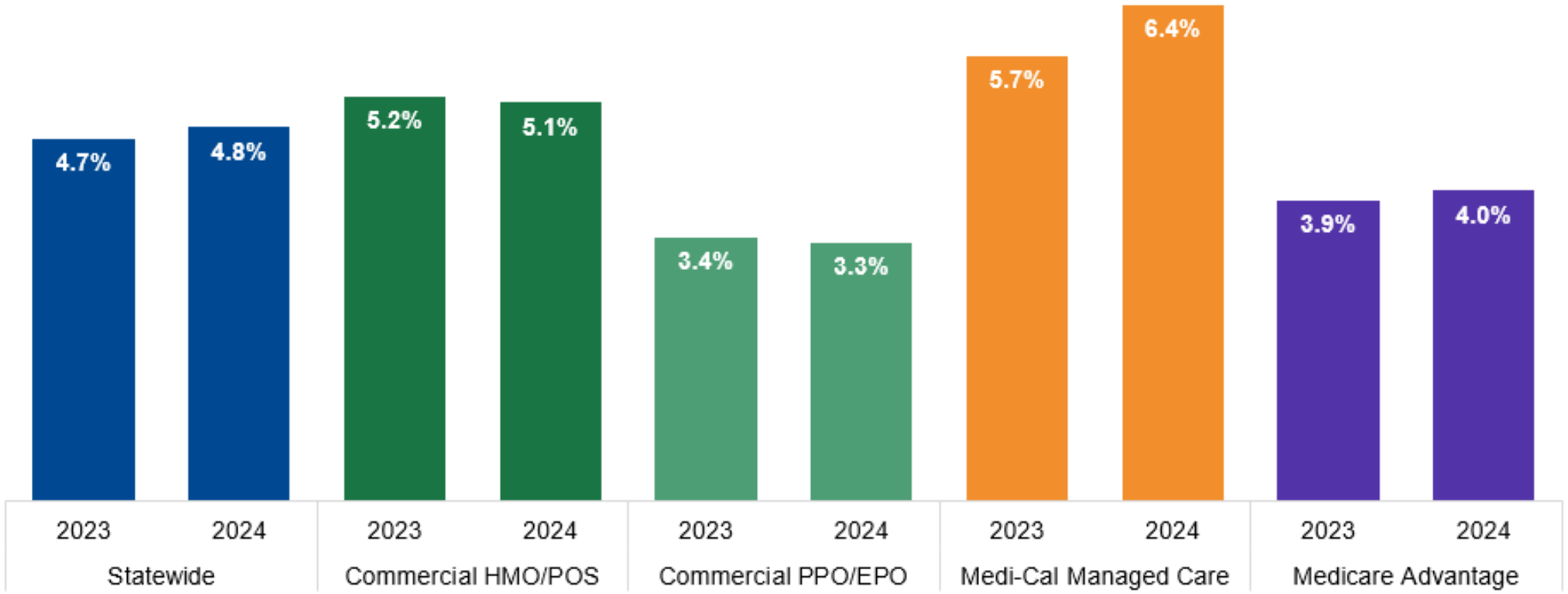
Year-over-year changes represent change in dollars spent



*Some payers' primary care spending data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

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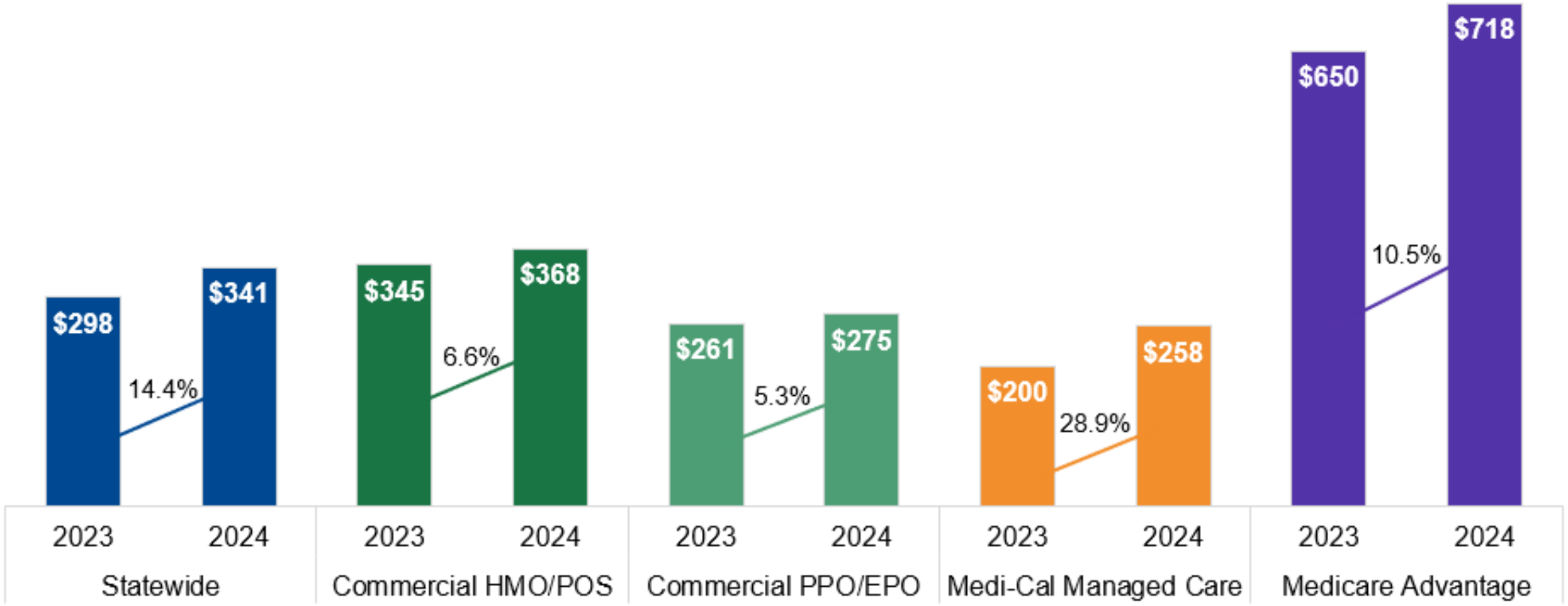
Primary Care Spending as Percent of Total Medical Expense (TME), Statewide and by Market and Plan Type*



Note: Medi-Cal Managed Care covered benefits do not align with those in other markets, making cross-market comparisons unreliable (e.g., Medi-Cal Managed Care TME does not include retail pharmacy spending).

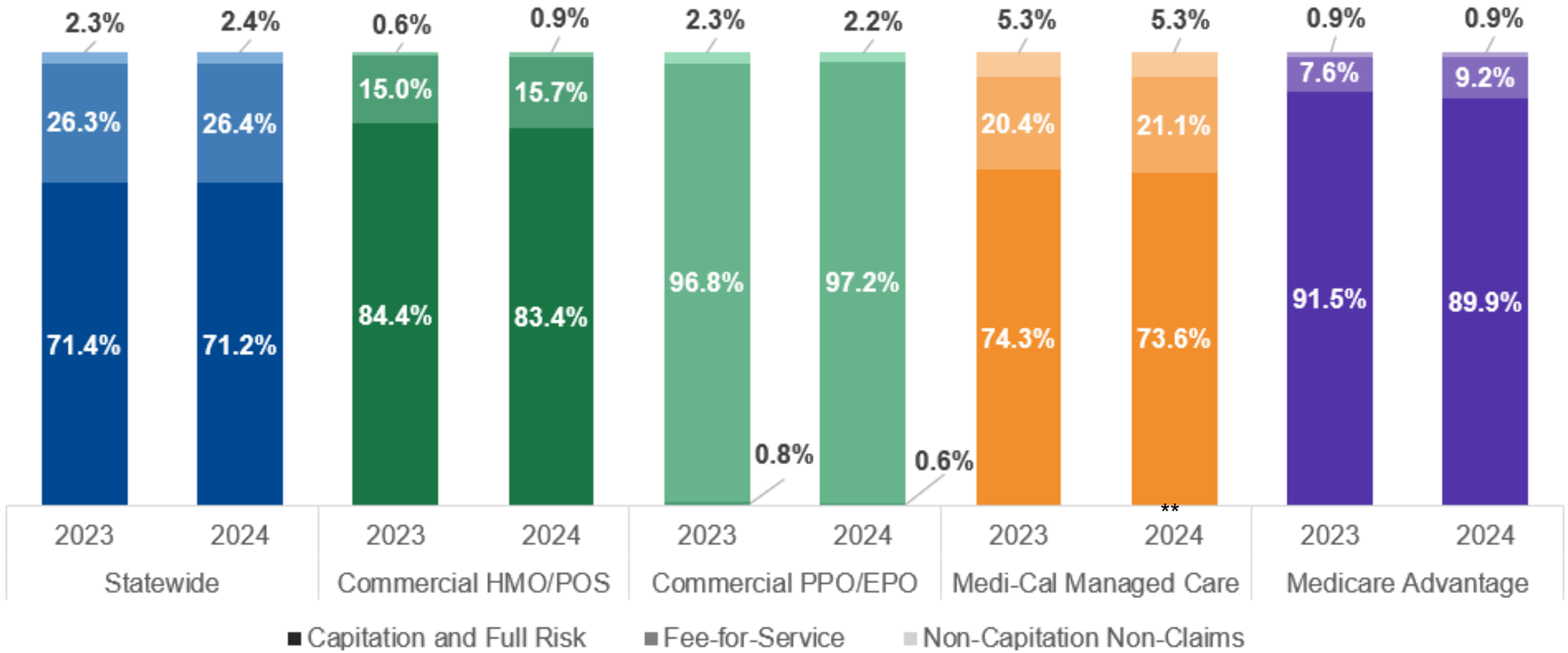
*Some payers' primary care spending data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

Primary Care Spending Per Member, Per Year, Statewide and by Market and Plan Type*



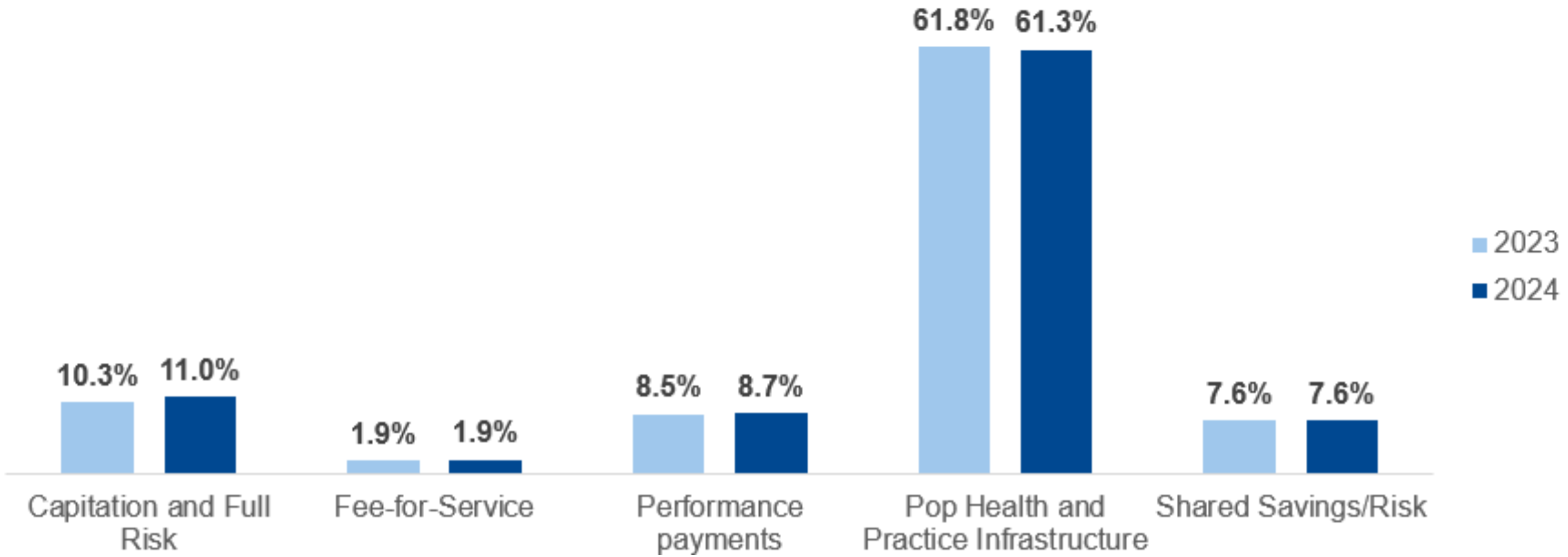
*Some payers' primary care spending data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

Primary Care Spending by Payment Category, Statewide and by Market and Plan Type*



*Some payers' primary care data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers. **Non-Capitation Non-Claims includes Performance Payments, Population and Practice Infrastructure Payments, Shared Savings and Shared Risk Payments, and Other Non-Claims Payments

Percent of Payment Category Allocated to Primary Care Statewide*



*Some payers' primary care data has been excluded due to data validation concerns which OHCA is working with them to resolve.

Discussion: Report on Promoting High Value Health Care in California, 2023-2024

- Do Workgroup members have any questions about the APM adoption and primary care spending data presented in the *Report on Promoting High Value Health Care in California, 2023-2024?*

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Update on Behavioral Health Spending Analyses and Benchmark Setting

Debbie Lindes, Health Care Delivery System Group Manager

Key Decisions for Setting a Behavioral Health Benchmark

Key Decisions for Benchmark Focus	Key Decisions for Benchmark Structure
1. Should the benchmark be the same across markets or tailored for each? 2. Should the benchmark focus only on certain behavioral health service subcategories (e.g., outpatient)? 3. Should the benchmark focus only on a specific diagnosis category (mental health or substance use disorder)? 4. Should the benchmark focus only on a specific population or age band (e.g., children/youth)? 5. Should the benchmark focus on in-network behavioral health spending?	1. Should the benchmark be a percentage of total medical expenses or a per member, per month amount? 2. Should the benchmark focus on incremental or long-term improvement, or some combination? 3. What should the timeline be for achieving the benchmark?

Summary of Analytic Findings Informing Benchmark Focus and Structure

OHCA proposes delaying setting a benchmark until OHCA's behavioral health data collection can provide additional information on key decisions.

Key Decision	Preliminary Recommendation
Should benchmark be the same across markets or tailored to each?	Tailored to each
Should the benchmark focus only on certain behavioral health service subcategories?	Maybe
Should the benchmark focus only on specific diagnosis category?	Maybe
Should the benchmark focus only on a specific population or age band?	No
Should the benchmark focus on in-network behavioral health spending?	No
Should the benchmark be a percentage of total medical expenses or a PMPM amount?	Additional information needed
Incremental or long-term improvement, or some combination, benchmark?	Incremental
What should the timeline be for achieving the benchmark?	Additional information needed

August Investment & Payment Workgroup Takeaways

- Members expressed support for preliminary recommendations and delaying benchmark setting
- Members and OHCA agree that without self-pay and out-of-plan spending, there is a piece of behavioral health spend missing
- Interest in exploring a benchmark focused on increasing substance use disorder (SUD) outpatient spend
- Interest to focus benchmark discussion on the systemwide behavioral health goals and what an investment benchmark can and can't do
- Potential additional analytic questions raised include:
  - How have total outpatient professional non-primary care behavioral health and applied behavior analysis (ABA) spending changed in absolute dollars?
  - What SUD services are most commonly provided in different care settings?

OHCA's Role in Improving Behavioral Health Outcomes

Systemwide Behavioral Health Goals

Behavioral health care that is:

- Accessible
- Comprehensive
- Coordinated
- Equitable
- High Quality

Motivate

Resulting In

California Stakeholder Actions

- Identify and support higher value care
- Build and sustain infrastructure and capacity
- Promote behavioral health integration with primary care and social and public health services
- Reduce disparities

Supports

OHCA's Behavioral Health Workstream

- Promote sustained systemwide investment in behavioral health
- **Measure and report** the percentage of total medical expenditures allocated to behavioral health care
- Set focused **spending benchmarks** to support improved behavioral health outcomes
- Conduct analysis

Healthcare Payments Data Program (HPD) Behavioral Health Analysis Updates

Commercial and Medicare Advantage

- *Completed*:
  - Behavioral health spending as a share of total claims spending and by plan within markets
  - In- vs. out-of-network shares of behavioral health spending by market
  - Behavioral health spending by age band by market
  - Spending on Applied Behavior Analysis (ABA) services
  - Variation by geography
- *Ongoing*:
  - Spending on claims with a behavioral health diagnosis in a non-primary position

Medi-Cal

- OHCA is working with DHCS to analyze and report non-managed care plan Medi-Cal behavioral health spending, including for specialty mental health and substance use disorder services, using HPD.

HPD Data Analysis – Approach and Limitations

- Analysis reflects spending from claims. Spending via capitation arrangements is not included.
- Analysis includes commercial and Medicare Advantage markets.
  - DHCS advised that Medi-Cal Managed Care Plan (MCP) spending data should be analyzed via OHCA payer submissions rather than HPD.
- Data was grouped by diagnosis category (i.e., mental health and substance use disorder) and service subcategory.*
- The HPD team continues to work with submitters to improve data quality. Health plans with known issues are excluded.
- Analyses of Covered California region spending were limited to plans meeting a set of inclusion criteria, to ensure results provide a full picture of claims spending on behalf of members (see appendix).
- Results presented today are preliminary.

*Service subcategories included on the next slide.

Behavioral Health Reporting Categories

Reporting Categories	Service Subcategories
Outpatient/Community Based	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility
	Emergency Department / Observation; Professional
Inpatient	Inpatient; Facility
	Inpatient; Professional
Residential	Residential Care
Other†	Other Behavioral Health Services
Pharmacy	Mental Health (MH) Prescription Drug Treatments Substance Use Disorder (SUD) Prescription Drug Treatments

†All spending for claims with a primary behavioral health diagnosis is included (i.e., spending not in other subcategories goes to "Other").

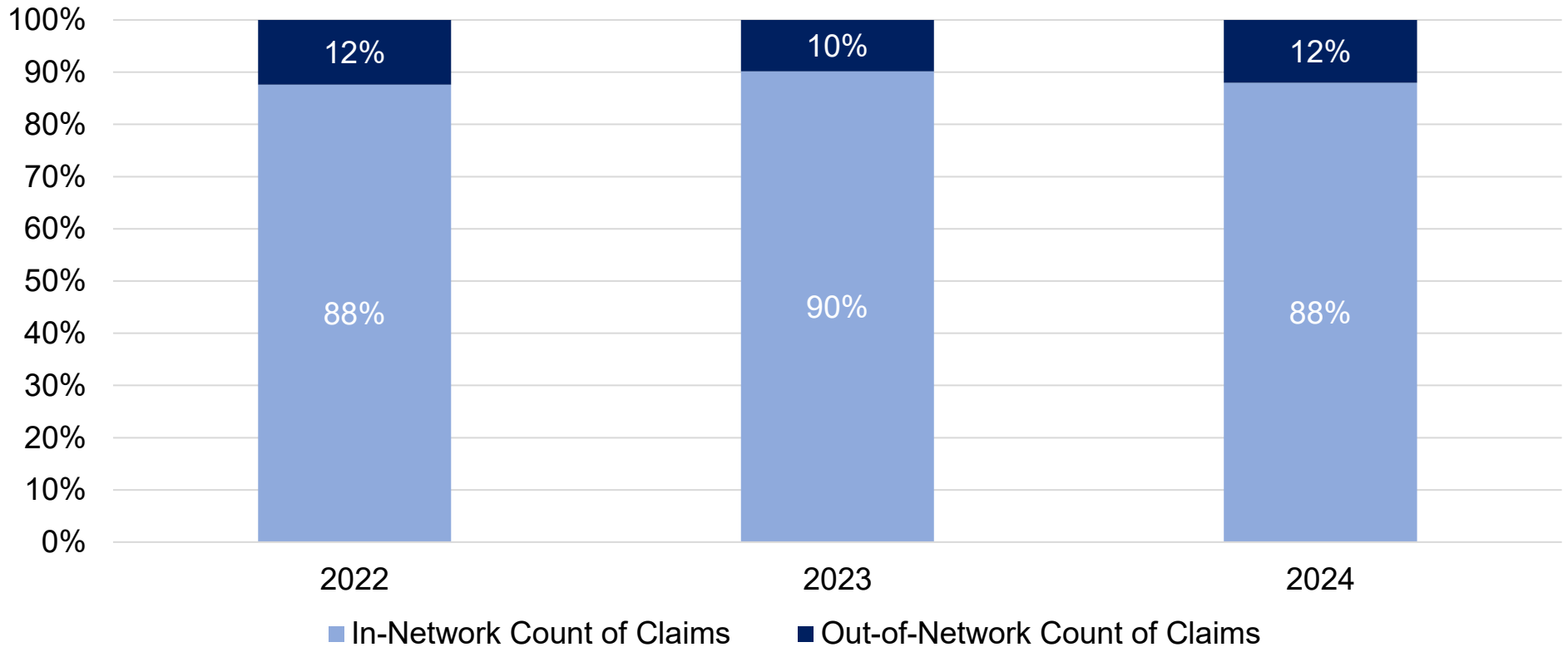
California Policy Context: Access to In-Network Behavioral Health Services

- SB855 (2020) amended the California Mental Health Parity Act. Among other requirements, it mandates coverage for out-of-network services at no more cost share than in-network coverage when access is not available within geographic and timely access standards.
- SB221 (2021) requires health plans to ensure that their contracted provider networks can offer non-urgent follow up appointments with a non-physician mental health or substance use disorder provider within 10 business days
  - Plans are required to arrange coverage outside the contracted network if medically necessary treatment is not timely available in-network
- Department of Managed Health Care (DMHC) behavioral health investigation reports found that 9 plans, out of 14 investigated, had Knox-Keene violations related to appointment availability and timely access.

SB855: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB855
SB221: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB221
DMHC Behavioral Health Investigation Reports: https://www.dmhc.ca.gov/Resources/DMHCReports/PublicReports.aspx#Behavioral

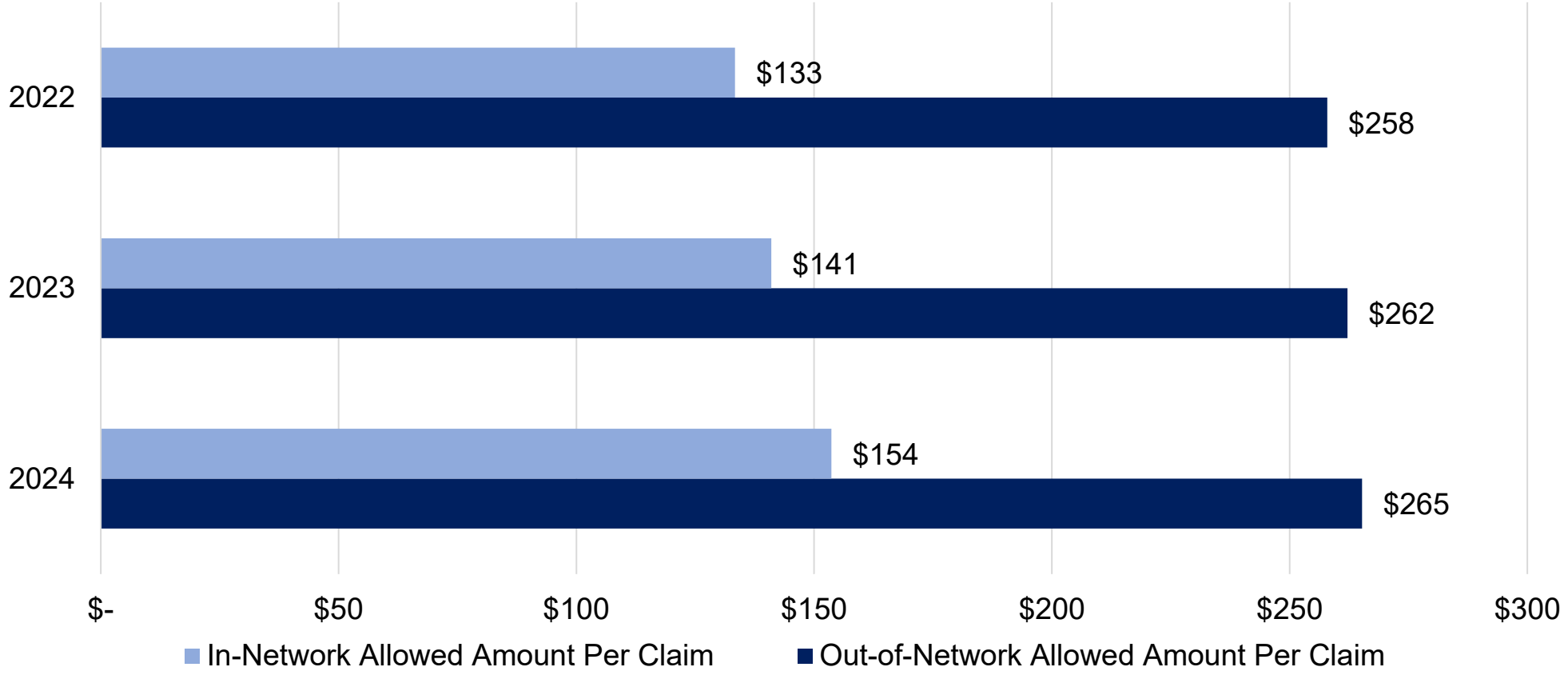
Commercial In- vs. Out-of-Network Share of Total Psychotherapy Claims

In the commercial market, in-network share of psychotherapy claims ranged from 88-90% from 2022 to 2024.



Commercial Psychotherapy In- vs. Out-of-Network Allowed Amount per Claim

Commercial out-of-network allowed amount per claim is almost double the in-network allowed amount.



Note: Allowed amount per claim is the sum of the plan paid and member responsibility amounts across all claims, divided by the total number of claims.

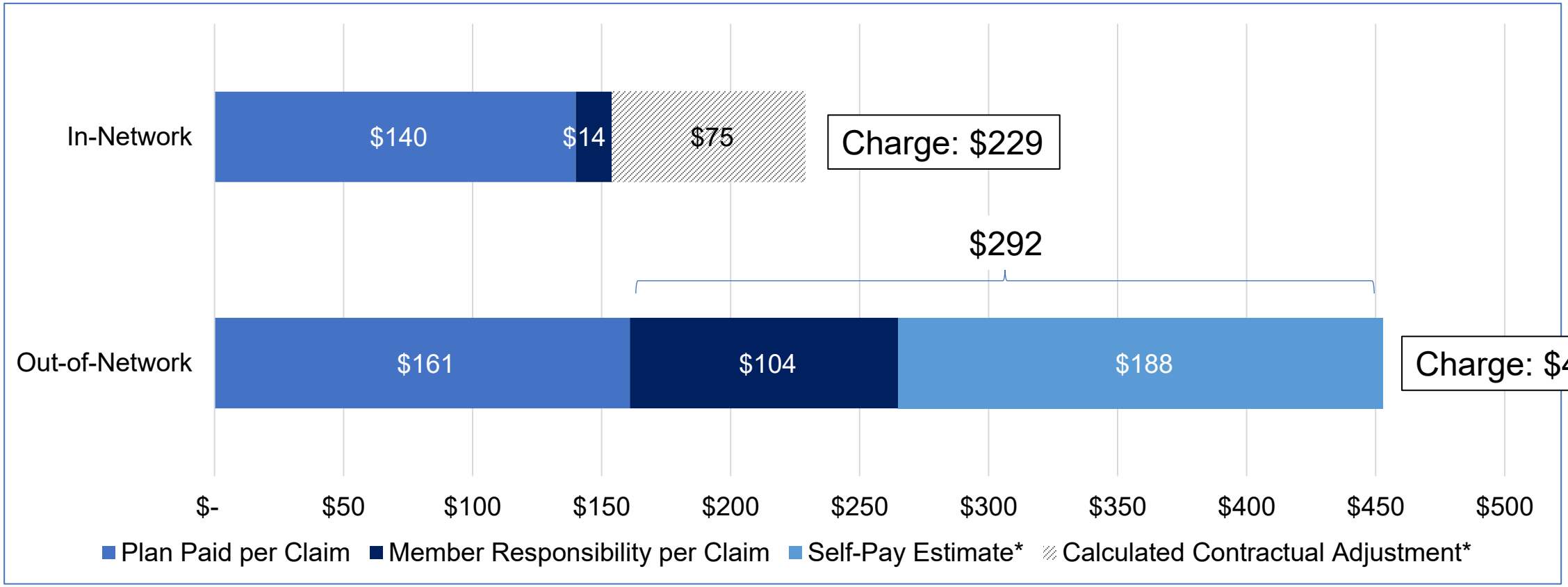
Background on Member vs. Plan Payments for In-Network vs. Out-of-Network Care

- "Member responsibility" for covered services includes co-insurance, co-pays, and deductible expenses. It does not include all payments by members when claims are not submitted by the provider and reimbursed directly to the provider by the health plan.
  - Members receiving psychotherapy from an out-of-network provider often pay the full charge amount up front and then receive a "superbill" from the provider to submit to their health plan.
  - The health plan reimburses the member for a portion of the charges, based on an out-of-network allowed amount ("reasonable and customary" amount) and out-of-network deductible/co-insurance terms.
- This means that members are likely paying closer to the charge amount than the "member responsibility" amount captured in the claims data.

Science Insights, April 2026. What is a Superbill and How Do You Get Reimbursed? https://scienceinsights.org/what-is-a-superbill-and-how-do-you-get-reimbursed/

Breakdown of Estimated Member vs. Plan Payment Amounts for In- vs. Out-of-Network Commercial Psychotherapy Claims, 2024

On average, commercial members pay an estimated $292 for out-of-network psychotherapy compared to only $14 for in-network psychotherapy.



*Estimated value that is not a Healthcare Payments Database (HPD) field.
Note: Member responsibility includes co-insurance, co-pays, and deductible expenses. It does not include all self-pay by members when claims are not submitted and reimbursed.

Key Benchmark Decision: Should the benchmark focus on in-network behavioral health spending?

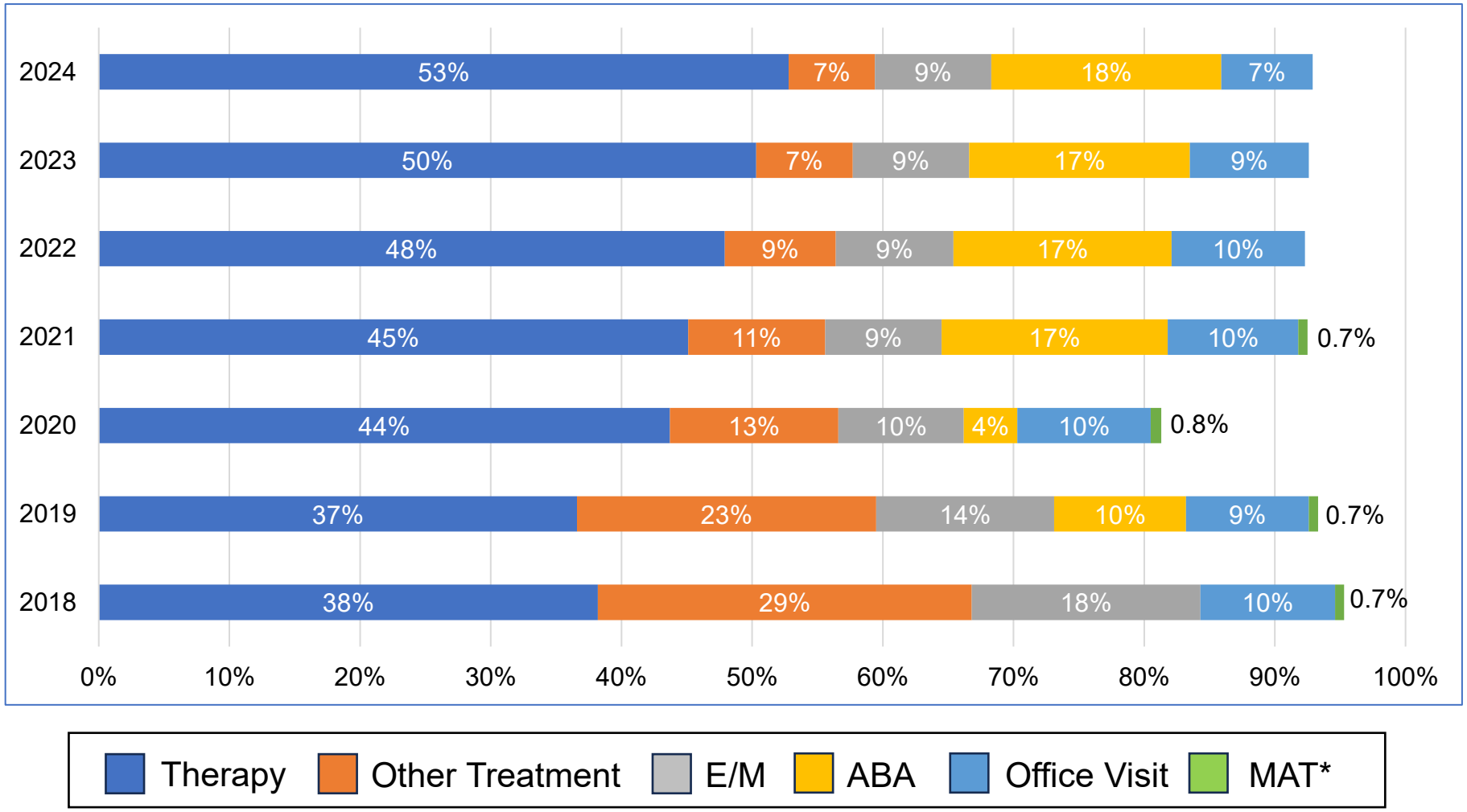
Analysis Recap	Benchmark Implication
• Commercial out-of-network allowed amount per claim is almost double the in-network allowed amount per psychotherapy claim. • Commercial psychotherapy in-network member responsibility per claim is significantly less than the out-of-network member responsibility per claim. • For out-of-network claims, members must also pay the difference between the allowed amount and the charged amount.	• The differences in consumer out-of-pocket payments for psychotherapy between in- and out-of-network claims could be targeted via an in-network behavioral health benchmark. • Without information on out-of-plan spending, a benchmark focused on in- vs. out-of-network spending cannot track changes in access to covered behavioral health care and total consumer out-of-pocket spending, but may support lower patient spending for psychotherapy services.

Outpatient Professional Non-Primary Care (Non-PC) Service Subcategory

- Professional claims with a primary behavioral health diagnosis code with certain places of service (POS) and service codes are categorized as Outpatient Professional Non-Primary Care.
  - Examples of care settings: Telehealth, Office, Home, Mobile Unit, Urgent Care Facility, Partial Hospitalization, Community Health Centers
  - Examples of services: Assessments and Evaluations, Interventions and Treatments, Office Visits, and Care Management
- Professional claims with a primary behavioral health diagnosis code that also meet OHCA's primary care provider, care setting, and service specifications are categorized as Outpatient Professional Primary Care.

Distribution of Commercial Outpatient Professional Non-Primary Care Spending

- Psychotherapy and adaptive behavior analysis (ABA) treatment increased as a share of outpatient professional non-PC spending from 2018 to 2024.
- Only ten service codes make up over 80% of outpatient professional non-PC spending.



*Medication-assisted treatment (MAT)
Note: "Other Treatment" includes therapeutic repetitive transcranial magnetic stimulation (TMS) and therapeutic behavioral services and "E/M" includes psychiatric diagnostic evaluations, self-care/home management training, and mental health service plan development.

Average Commercial Allowed Amount per Claim Line and Total Number of Claim Lines Across Top 20 Outpatient Professional Non-PC Services

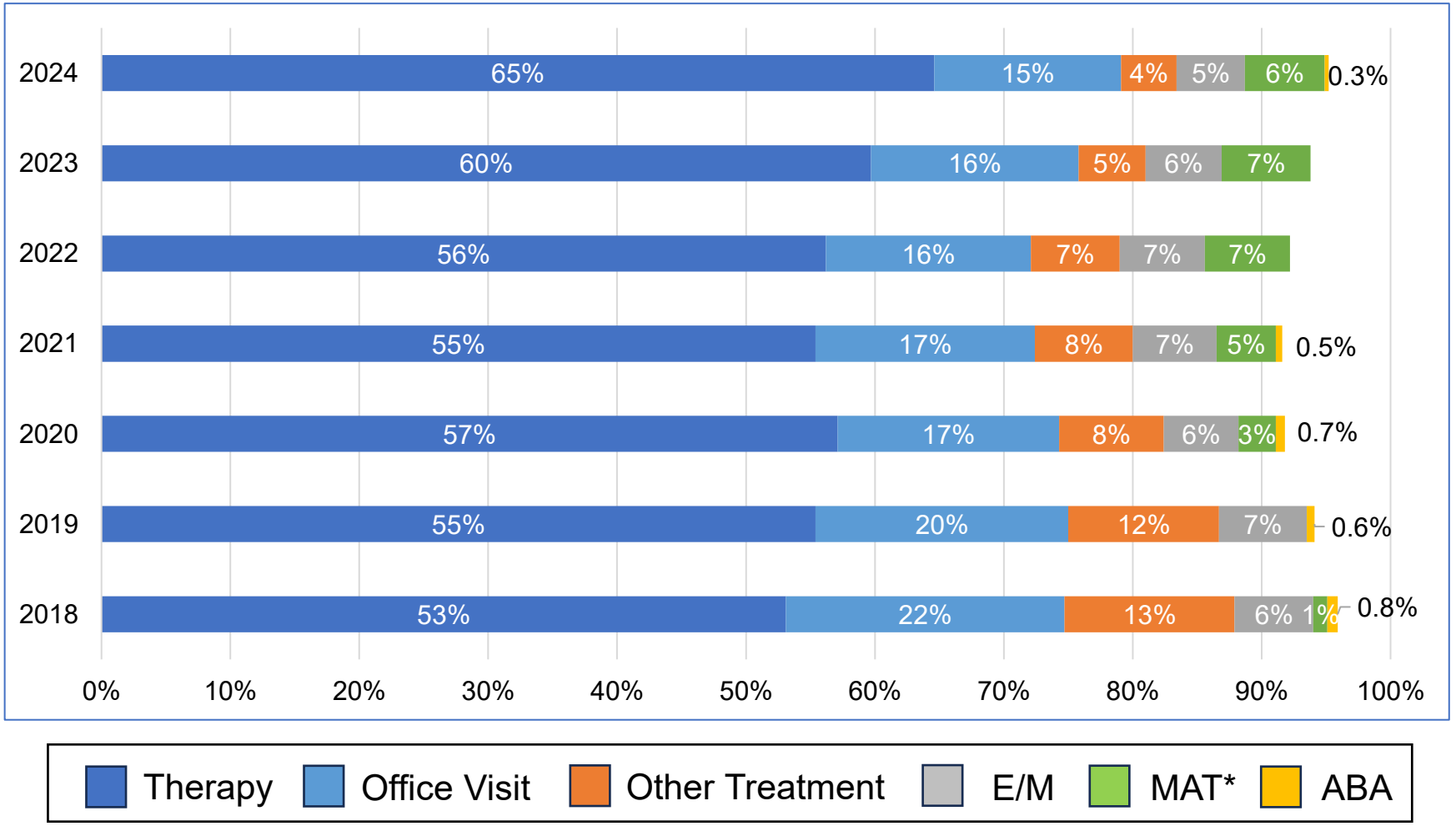
Count of claim lines (utilization) increased much more than the average allowed amount per claim line ("price") for outpatient professional non-PC services.

	Average Allowed Amount per Claim Line	Count of Claim Lines
2018	$141	7,030,358
2024	$167	14,056,388
Percent Increase	18.4%	99.9%

Note: Average allowed amount and count of claim lines calculations are for the twenty service codes associated with the most outpatient professional non-primary care behavioral health spending.

Distribution of Medicare Advantage Outpatient Professional Non-PC Spend

- Psychotherapy increased as a share of outpatient professional non-PC spending from 2018 to 2024.



*Medication-assisted treatment (MAT)
Note: "Other Treatment" includes therapeutic repetitive transcranial magnetic stimulation (TMS) and therapeutic behavioral services and "E/M" includes psychiatric diagnostic evaluations, self-care/home management training, and mental health service plan development.

Average Medicare Advantage Allowed Amount per Claim Line and Total Number of Claim Lines Across Top 20 Outpatient Professional Non-PC Services

Like commercial, the Medicare Advantage count of claim lines (utilization) increased much more than the average allowed amount per claim line ("price") for outpatient professional non-PC services.

	Average Allowed Amount per Claim	Count of Claim Lines
2018	$114	181,268
2024	$155	584,216
Percent Increase	36.0%	222.3%

Note: Average allowed amount and count of claim lines calculations are for the twenty service codes associated with the most outpatient professional non-primary care behavioral health spending.

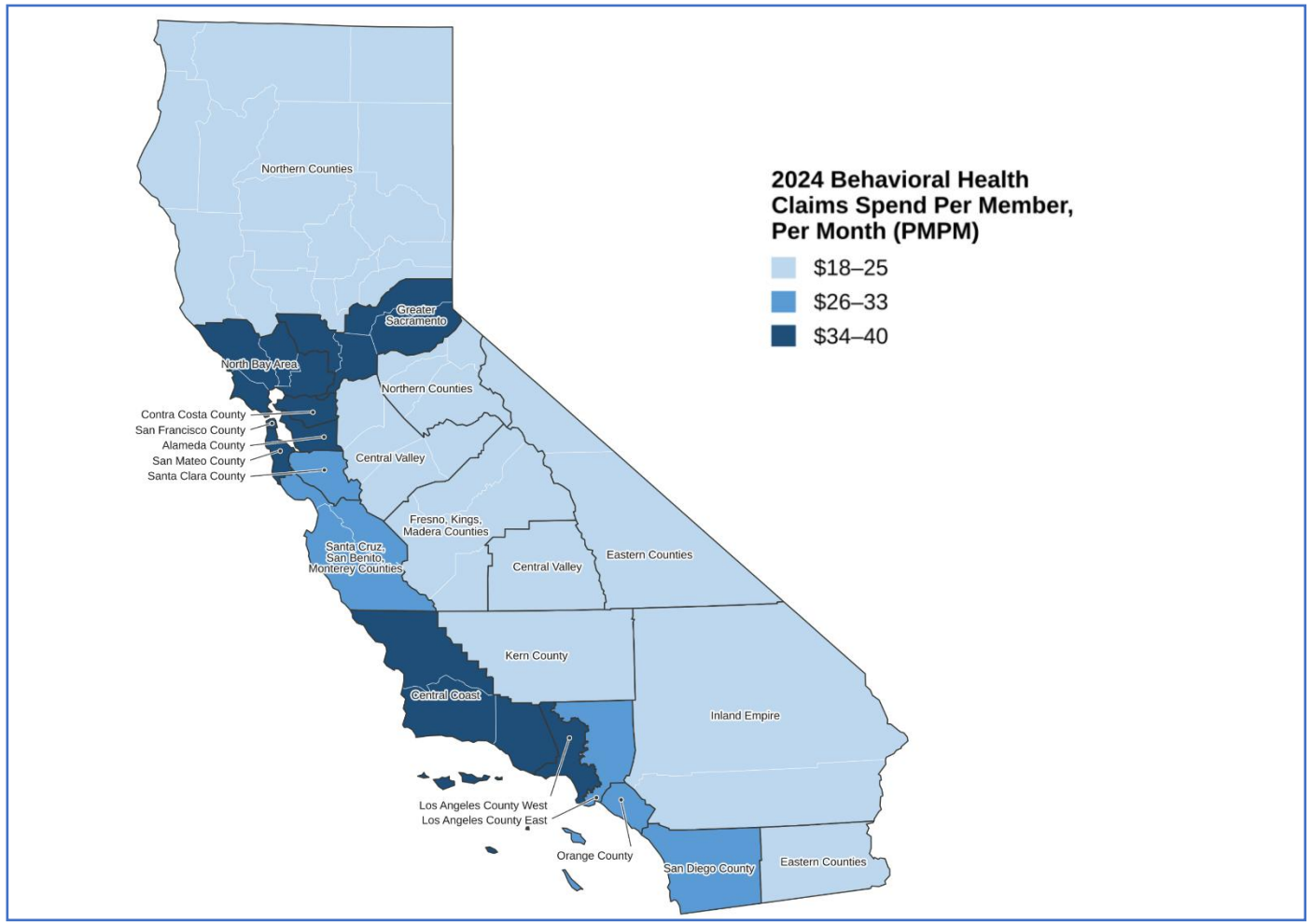
Key Benchmark Decision: Should the benchmark focus only on certain behavioral health service subcategories?

Analysis Recap	Benchmark Implication
• Psychotherapy and adaptive behavior analysis (ABA) treatment increased as a share of outpatient professional non-PC spending from 2018 to 2024. • Only a few types of services (e.g., psychotherapy, office visits, diagnostic evaluations) make up over 80% of outpatient professional non-PC spend for both markets.	• A benchmark focused on outpatient spending would be heavily influenced by psychotherapy and ABA spending.

OHCA's 2027 behavioral health spend reporting-will provide more information on differences in service subcategory spending by market and plans.

2024 Commercial BH Claims Spending Per Member, Per Month (PMPM) by Covered CA Region

- Commercial behavioral health claims spending varies by Covered California region.
- Spending is higher in urban, coastal regions than in central valley, inland empire, and northern regions.

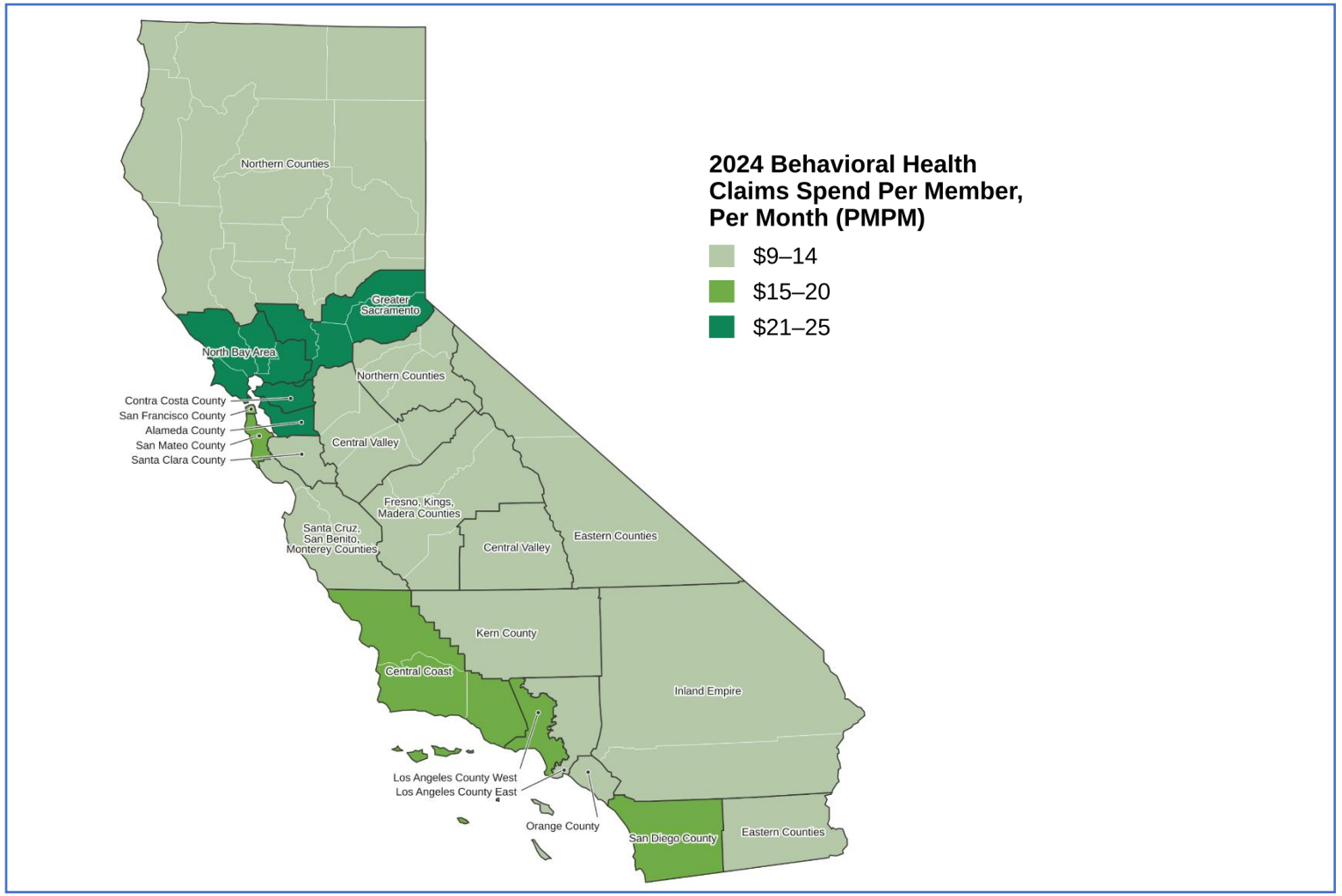


Data table with 2024 behavioral health claims spending PMPM by Covered California region can be found in the Appendix.

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2024 Medicare Advantage BH Claims Spending PMPM by Covered CA Region

- Medicare Advantage behavioral health claims spending varies by Covered California region.
- Regional spending patterns are similar to those in the commercial market.



Data table with 2024 behavioral health claims spending PMPM by Covered California region can be found in the Appendix.

Key Benchmark Decision: Should the benchmark focus on incremental or long-term improvement, or some combination?

Analysis Recap	Benchmark Implication
• Commercial and Medicare Advantage behavioral health spending as a per member, per month (PMPM) amount varies by Covered California region.	• **An incremental improvement benchmark** would recognize differences in baseline behavioral health claims spending across Covered California regions. • **A long-term improvement benchmark's** impacts could vary by geography.

Summary of Analytic Findings Informing Benchmark Focus and Structure

OHCA proposes delaying setting a benchmark until OHCA's behavioral health data collection can provide additional information on key decisions.

Key Decision	Preliminary Recommendation
Should benchmark be the same across markets or tailored to each?	Tailored to each
Should the benchmark focus only on certain behavioral health service subcategories?	Maybe
Should the benchmark focus only on specific diagnosis category?	Maybe
Should the benchmark focus only on a specific population or age band?	No
Should the benchmark focus on in-network behavioral health spending?	**Yes**
Should the benchmark be a percentage of total medical expenses or a PMPM amount?	Additional information needed
Incremental or long-term improvement, or some combination, benchmark?	Incremental
What should the timeline be for achieving the benchmark?	Additional information needed

Discussion

- Do Workgroup members have questions or feedback on the connections between analytic findings and their implications for benchmark focus and structure, specifically whether the benchmark should be:
  a. Focused on a specific behavioral health service subcategory?
  b. Focused on in-network behavioral health spend?
  c. Incremental, long-term, or a combination?

Next Steps for Behavioral Health Investment Benchmark

- OHCA will continue conducting additional analyses on behavioral health claims spending (e.g., spending for non-primary BH diagnoses)
- OHCA plans to bring updates on the behavioral health analyses and investment benchmark to the Board in November and the Advisory Committee in January
- Future Workgroup meetings will review additional HPD analyses and return to discussing key benchmark decisions

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Next Steps

Margareta Brandt, Assistant Deputy Director

Next Steps

- 2027 Meeting Schedule:
  - February 17, 2027*
  - May 19, 2027
  - August 18, 2027
  - November 17, 2027

- Upcoming topics
  - Continued Discussion of Behavioral Health Spending Analyses and Investment Benchmark Implications

*Next meeting date

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Adjournment

Margareta Brandt, Assistant Deputy Director

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Appendix

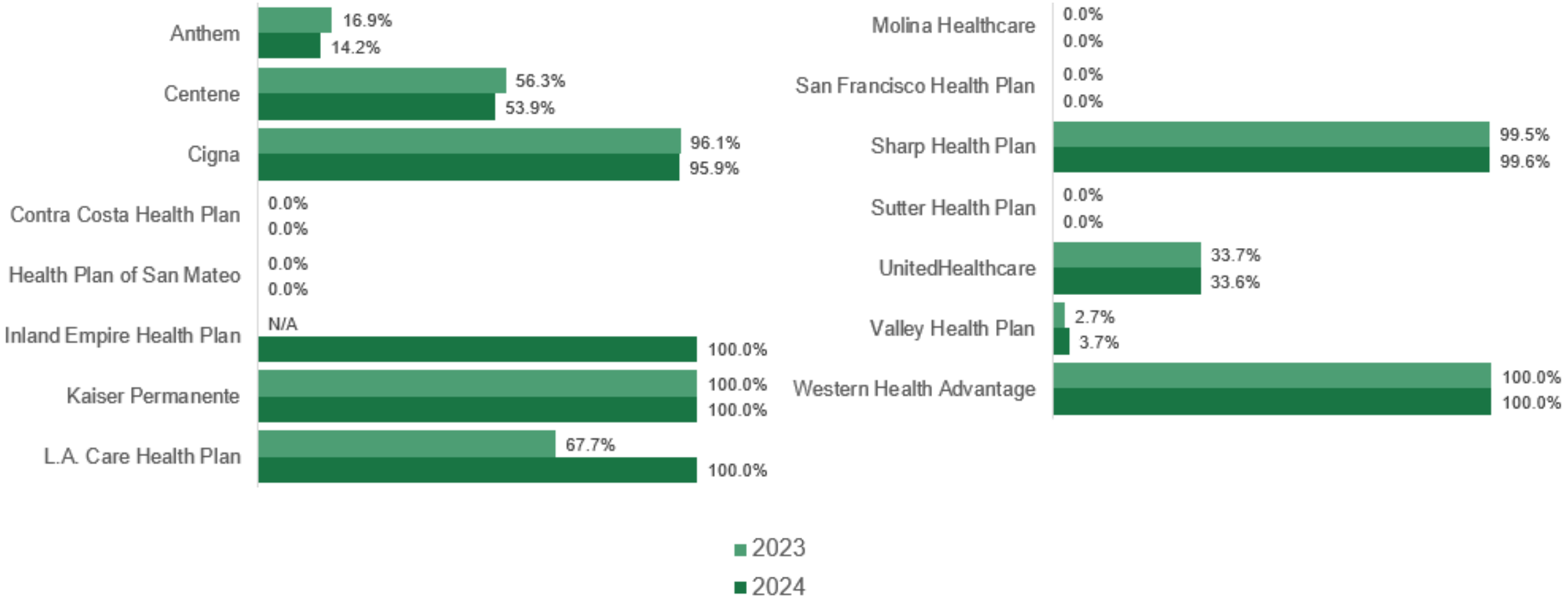
Key Findings from Report on Promoting High Value Health Care in California, 2023-2024

Exclusions

- APM adoption data have been excluded due to ongoing data validation concerns for[1]:
  - Aetna (Commercial HMO/POS, PPO/EPO, and Medicare Advantage)
  - Blue Shield of CA (Commercial HMO/POS, PPO/EPO, Medi-Cal Managed Care, and Medicare Advantage)
  - Kern Family Health (Medi-Cal Managed Care)
- APM adoption and primary care spending data have been excluded due to ongoing data validation concerns for[1]:
  - Alignment Health (Medicare Advantage)
- Commercial PPO/EPO payer-level reporting excluded due to low enrollment in PPO plans for:
  - Kaiser Permanente and Sharp Health Plan
- OHCA's measurement of APM adoption and primary care spending reporting excludes a variety of payments and spending including but not limited to:
  - Medicare Fee-for-Service (FFS) and supplemental insurance payments, Medi-Cal FFS and Medi-Cal pharmacy spending, "Commercial – Other" market spending (enrollment and spending in this category represented less than 1% of the Commercial market), a portion of commercial self-insured spending, other state and federal program spending, spending from payers with fewer than 40,000 covered lives in any market, reinsurance recoveries.

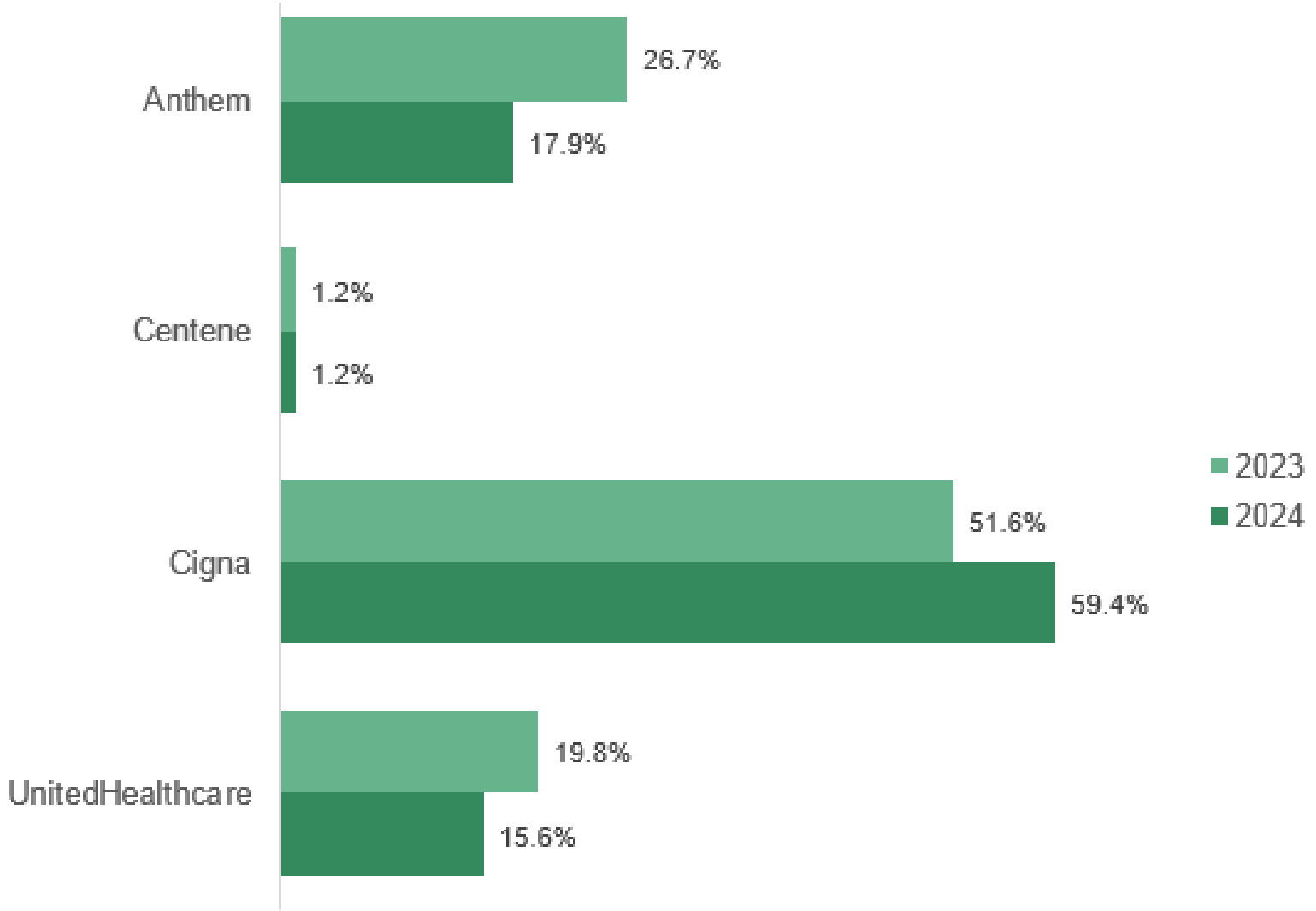
[1]OHCA is working with these payers to resolve ongoing data validation concerns.

Commercial HMO/POS Members Attributed to APMs with Quality-Linked Payments*



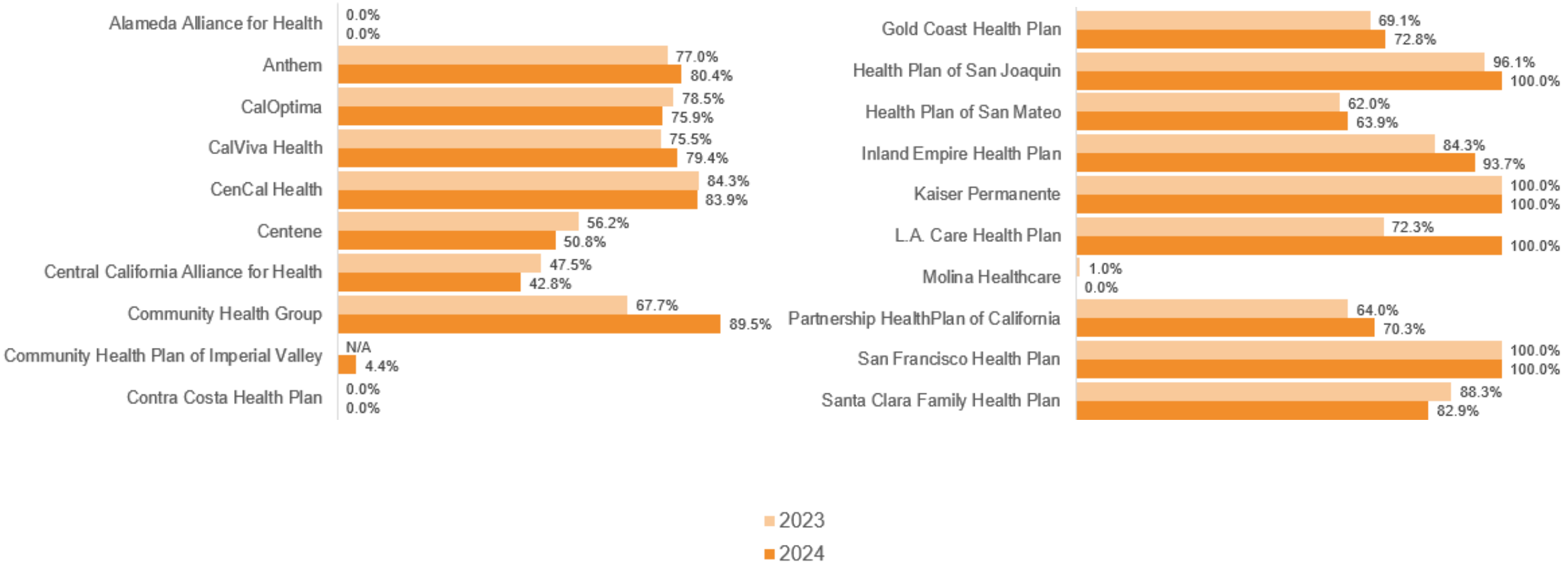
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to the Exclusions slide for more details on excluded payers.

Commercial PPO/EPO Members Attributed to APMs with Quality-Linked Payments*



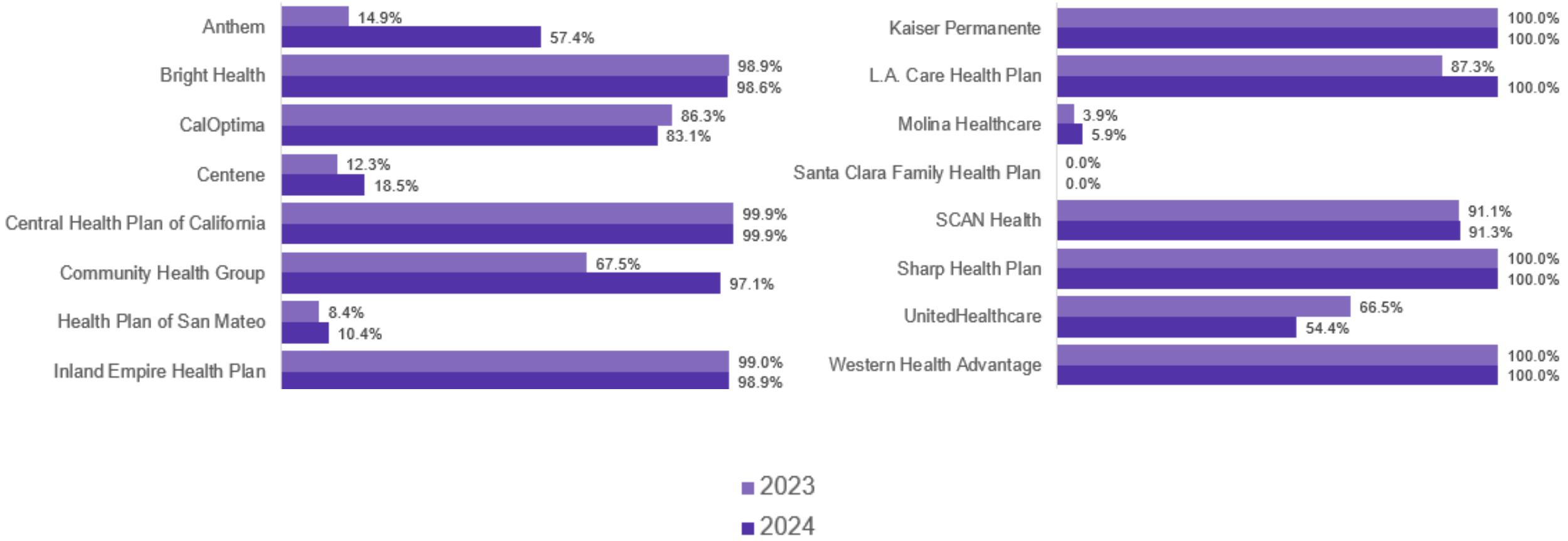
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Kaiser and Sharp Health Plan's data has been excluded due to low member months in this market. Refer to the Exclusions slide for more details on excluded payers.

Medi-Cal Managed Care Members Attributed to APMs with Quality-Linked Payments*



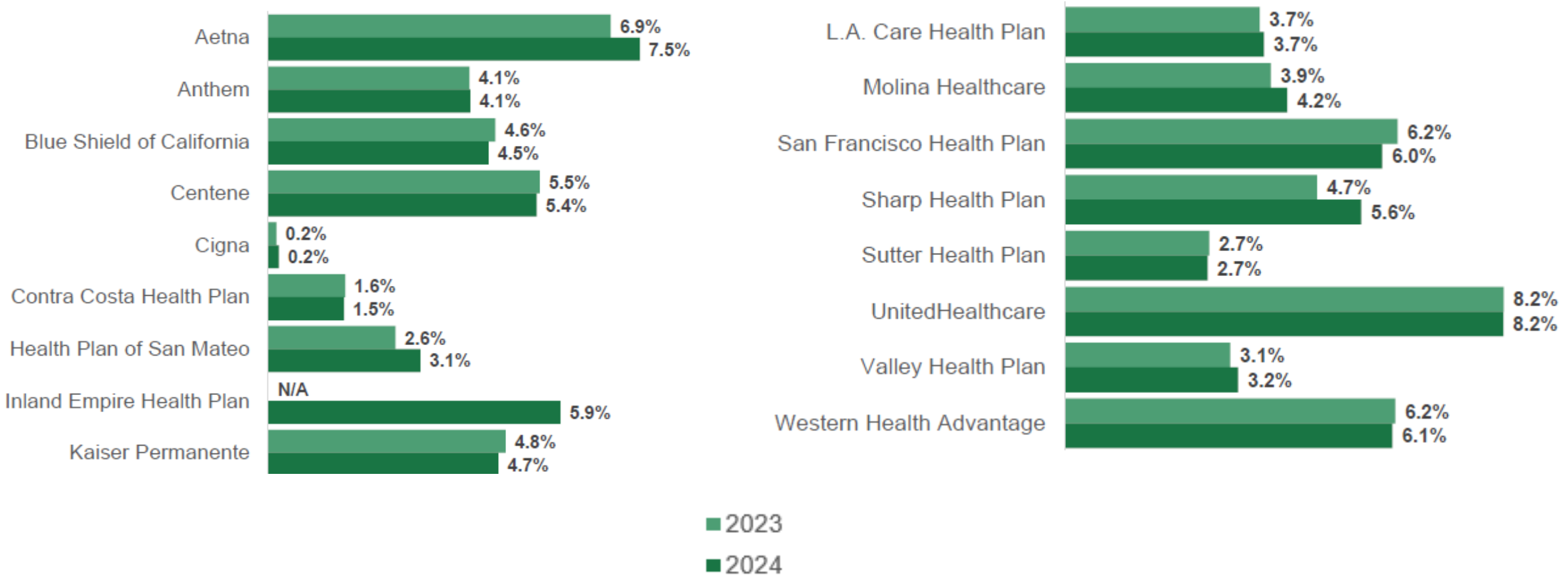
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to the Exclusions slide for more details on excluded payers.

Medicare Advantage Members Attributed to APMs with Quality-Linked Payments*

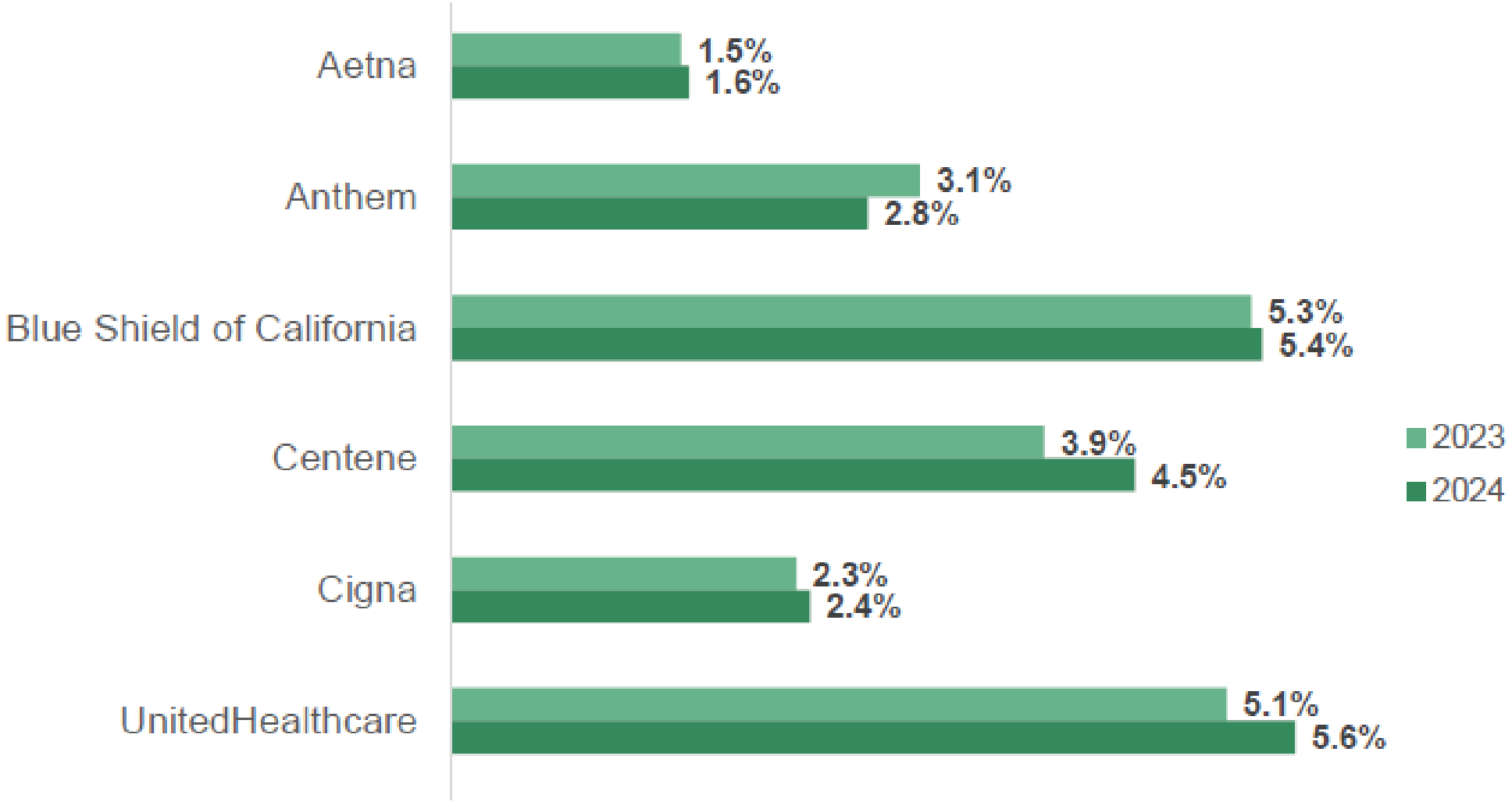


*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to the Exclusions slide for more details on excluded payers.

Commercial HMO/POS Primary Care Spending as a Percent of TME

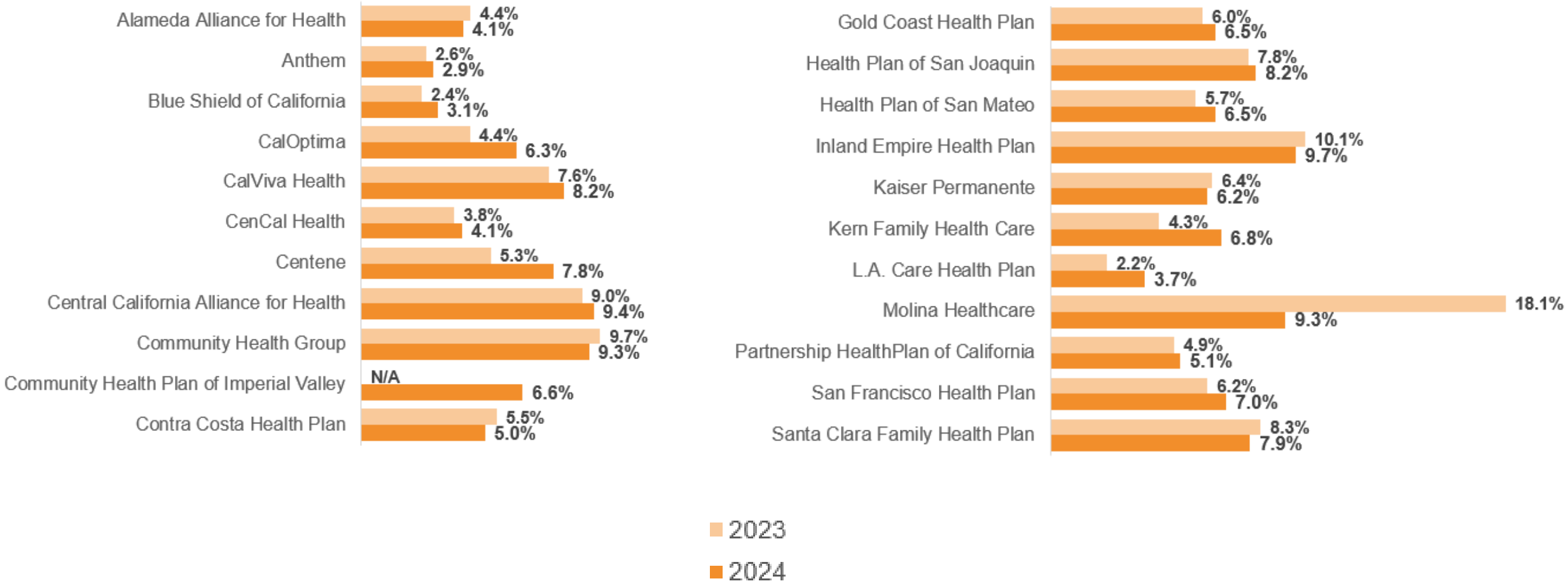


Commercial PPO/EPO Primary Care Spending as a Percent of TME*



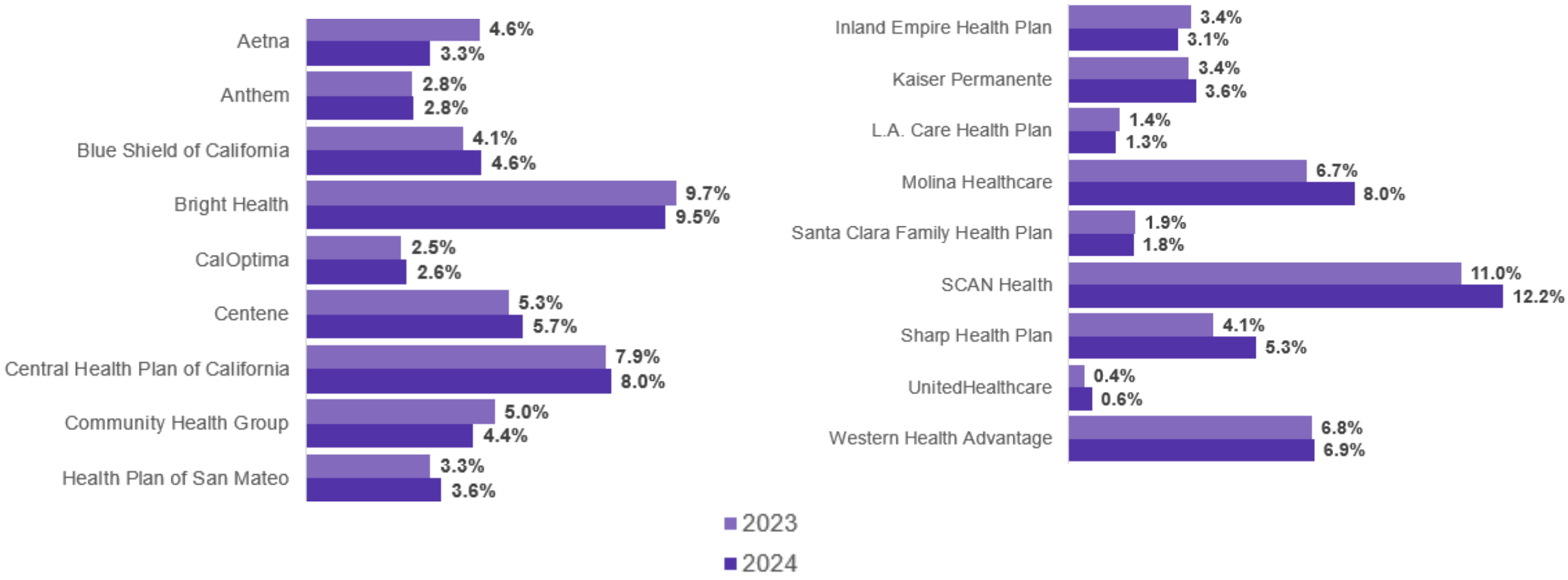
*Kaiser and Sharp Health Plan's data has been excluded due to low member months in this market.

Medi-Cal Managed Care Primary Care Spending as a Percent of TME*



*Molina Healthcare reported an increase and change in membership population served, along with provider network composition changes which impacted the primary care spending as a percent of TME in the Medi-Cal Managed Care market between 2023 and 2024.

Medicare Advantage Primary Care Spending as a Percent of TME*



*Some payers' primary care data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to the Exclusions slide for more details on excluded payers.

Update on Behavioral Health Spending Analyses and Benchmark Setting

Applying Exclusions to Plan-level Analyses

- To set a behavioral health benchmark that applies across plans within a market and/or across markets, understanding inter-plan variation in levels of behavioral health spending, and in spending distribution across service subcategories, is necessary.
- Plan-level analyses conducted without exclusions showed extremely wide ranges of spending across plans and across spending subcategories.
  - Some plans carved out behavioral health and had no spending, others carved out pharmacy, etc.
- OHCA developed a set of inclusion criteria, to enable analysis limited to plans for which a full picture of claims spending on behalf of members is available.
  - OHCA believes that applying these criteria results in a more accurate picture of the true range of behavioral health spending as a share of total claims spending, to inform a benchmark for behavioral health spending.

Criteria for Inclusion in Analysis

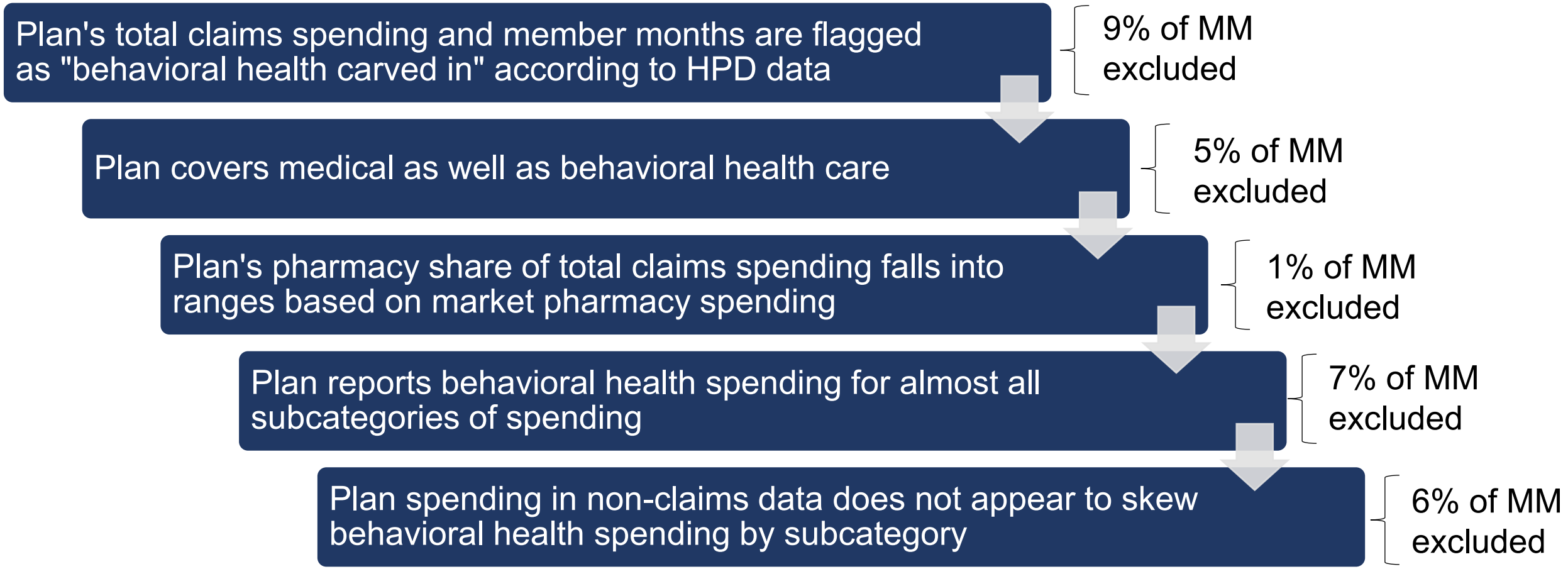
Plan-product combinations are included in the summary analysis if the:

- ✓ Plan's total claims spending and member months are flagged as "behavioral health carved in" according to the HPD.
- ✓ Plan covers medical as well as behavioral health care.
- ✓ Plan's pharmacy share of total claims spending falls into ranges based on market pharmacy spending in the upcoming 2026 OHCA Interim Report on total health care expenditures.
  - Commercial: Pharmacy share of total claims spending falls between 10% and 40%.
  - Medicare Advantage: Pharmacy share of total claims spending falls between 15% and 45%.
- ✓ Plan reports behavioral health spending for almost all subcategories of spending.
  - Plans missing two or more subcategories of spending, aside from Residential, are excluded.*
  - Plans missing pharmacy spending are excluded.
- ✓ Plan spending in non-claims does not appear to skew behavioral health spending by subcategory.

*Residential behavioral health is not required to be covered for Medicare Advantage plans

2024 Commercial Example: Impact of Applying Criteria for Inclusion

The flow chart shows the share of member months (MM) excluded after applying each criterion. Plan-specific commercial analyses include 72% of MM for 2024.



Percent of 2024 commercial MM excluded because of step

2024 Top 20 (1-10) Service Codes Associated with the Most Commercial Outpatient Professional Non-PC Spend

Rank	Code	Description
1	90837	Psychotherapy, 60 minutes with patient
2	97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
3	90834	Psychotherapy, 45 minutes with patient
4	H2019	Therapeutic behavioral services, per 15 minutes
5	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
6	97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
7	90791	Psychiatric diagnostic evaluation
8	H0032	Mental health service plan development by non-physician
9	90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic
10	90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

2024 Top 20 (11-20) Service Codes Associated with the Most Commercial Outpatient Professional Non-PC Spend

Rank	Code	Description
11	90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, subsequent delivery and management, per session
12	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
13	H0004	Behavioral health counseling and therapy, per 15 minutes
14	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
15	97151	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
16	97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
17	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
18	90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
19	90792	Psychiatric diagnostic evaluation with medical services
20	97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver

2024 Top 20 (1-10) Service Codes Associated with the Most Medicare Advantage Outpatient Professional Non-PC Spend

Rank	Code	Description
1	90837	Psychotherapy, 60 minutes with patient
2	90834	Psychotherapy, 45 minutes with patient
3	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
4	G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program)
5	90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, subsequent delivery and management, per session
6	90791	Psychiatric diagnostic evaluation
7	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
8	G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation
9	90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
10	H0020	Alcohol and/or drug services; methadone administration and/or service

2024 Top 20 (11-20) Service Codes Associated with the Most Medicare Advantage Outpatient Professional Non-PC Spend

Rank	Code	Description
11	90832	Psychotherapy, 30 minutes with patient
12	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
13	90792	Psychiatric diagnostic evaluation with medical services
14	90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
15	96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour
16	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
17	H2022	Community-based wrap-around services, per diem
18	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
19	97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
20	G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation

2024 Commercial PMPM Behavioral Health Claims Spending by Covered California Region

Covered CA Region	PMPM Behavioral Health Claims Spend
San Francisco County	$40
Los Angeles County West	$38
Greater Sacramento	$37
North Bay Area	$36
San Mateo County	$36
Central Coast	$35
Contra Costa County	$35
Alameda County	$34
San Diego County	$32
Orange County	$29
Santa Cruz, San Benito, Monterey Counties	$29
Santa Clara County	$28
Los Angeles County East	$27
Inland Empire	$25
Northern Counties	$22
Central Valley	$22
Eastern Counties	$20
Fresno, Kings, Madera Counties	$20
Kern County	$18

2024 Medicare Advantage PMPM Behavioral Health Claims Spending by Covered California Region

Covered CA Region	PMPM Behavioral Health Claims Spend
North Bay Area	$24
Greater Sacramento	$23
Alameda County	$22
Contra Costa County	$21
San Diego County	$19
Central Coast	$18
San Francisco County	$16
Los Angeles County West	$16
San Mateo County	$15
Northern Counties	$14
Central Valley	$13
Santa Clara County	$13
Orange County	$13
Inland Empire	$12
Los Angeles County East	$12
Santa Cruz, San Benito, Monterey Counties	$12
Fresno, Kings, Madera Counties	$11
Kern County	$10
Eastern Counties	$9